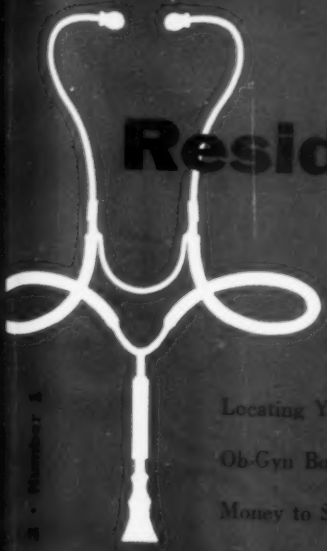

Resident Physician

January 1968 • Volume 8 • Number 1

Journal for the Hospital Resident

Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

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Antacid • Adsorbent

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because
your allergic patients
need a lift
a new R_x . . .

Plimasin®

(tripelennamine hydrochloride and methyl-phenidylacetate CIBA)

new, mild stimulant
and antihistamine

boost their spirits . . . relieve their allergic symptoms

So often the allergic patient is tired, irritable, depressed—mentally and physically debilitated. Frequently, antihistaminic agents themselves are sedative, adding to this already fatigued and disconsolate state.

Plimasin, because it combines a proved antihistamine with a new, mild psychomotor stimulant, overcomes depression and fatigue while it achieves *potent* antiallergic effects. Its new stimulant component—Ritalin—is totally different from amphetamine: smoother, gentler in action, devoid of pressor effect.

DOSAGE: *One or 2 tablets as required.*

Each Plimasin tablet contains 25 mg. Pyribenzamine® hydrochloride (tripelennamine hydrochloride CIBA) and 5.0 mg. Ritalin® (methyl-phenidylacetate CIBA).

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Contents

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January 1956, Vol. 2, No. 1

Articles

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Resident Physician

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Departments

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Resident Physician

January 1956, Vol. 2, No. 1

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted. Articles with photographs, illustrations or drawings are especially desired.

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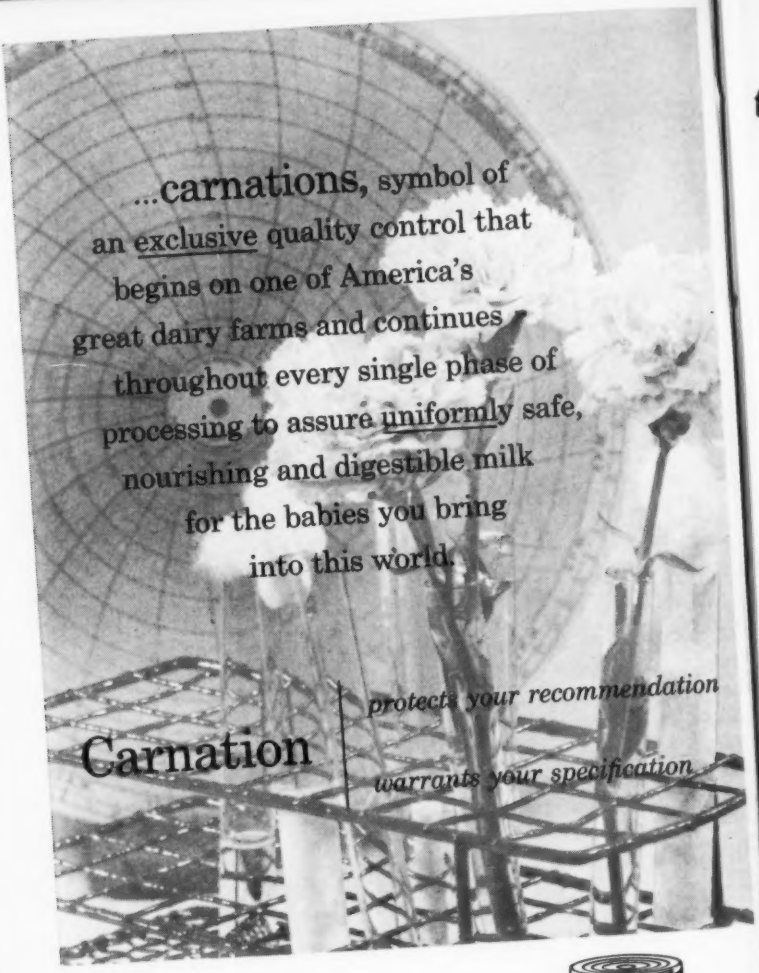

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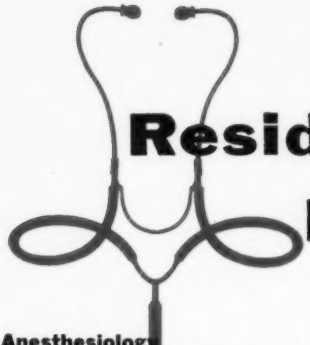
Resident Physician



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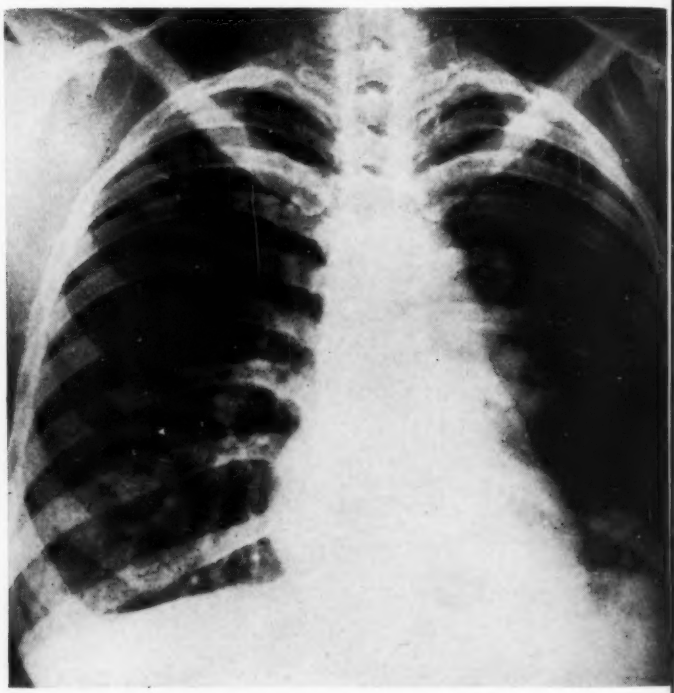
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

WHICH IS *YOUR* DIAGNOSIS?

1. Abscess
2. Abscess in malignancy
3. Abscess in infarct
4. Bleb
5. Bronciectasis

(Answers on Page 130)



a "judicious combination..."

for antiarthritic therapy

SALCORT*

That cortisone and the salicylates have a complementary action has been well established.[1-5] In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

One clinician states: "By a judicious combination of the two agents . . . it has been possible to bring about a much more favorable reaction in arthritis than with either alone. Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

INDICATIONS:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

EACH TABLET CONTAINS:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
Aluminum hydroxide gel, dried	0.12 Gm.
Calcium ascorbate (equivalent to 50 mg. ascorbic acid)	60 mg.
Calcium carbonate	60 mg.

* U.S. Pat. 2,691,662

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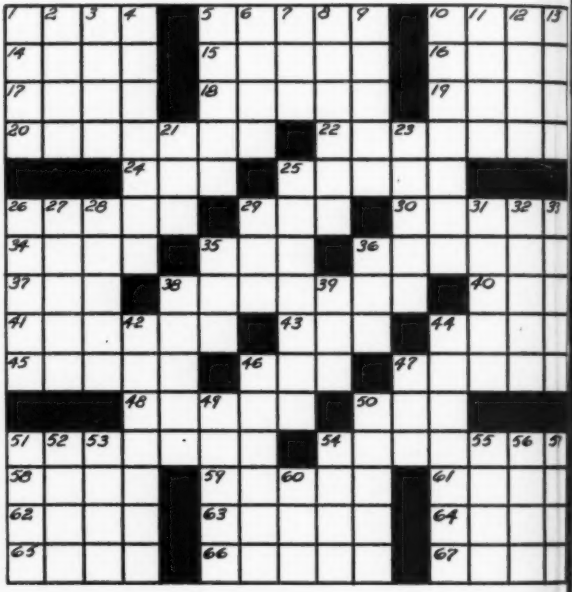
(Answer on page 130)



ACROSS

1. Dusting powder
5. Relating to an artery
10. Bottle stopper
14. External occipital protuberances
15. Secondary amine
16. The external genitalia
17. A common disorder
18. Early Greek physician
19. Portion of the brain
20. Tonic spasm
22. Bright's disease
24. Volume (abbr.)
25. The unnatural longings of pregnancy
26. French neurological surgeon (1840-1921)
29. Vegetable
30. The olivary eminence
34. Lower lateral nasal cartilage
35. To eat the evening meal
36. Instrument used to withdraw fluid
37. Brazilian River
38. Alfred Adler's birthplace
40. Mercuric oxide (abbr.)
41. Procure (another) to commit perjury
43. Lubricate
44. French coins
45. River in France (poss.)
46. London surgeon (1834-1902)
47. Succinct
48. Ossa
50. Cheilitis affects this
51. Prepared slides for microscopic examination
54. Sugar-splitting enzyme
58. A foal
59. Relating to the velum
61. Gastric acidity
62. Region
63. A natural earth used as pigment
64. Metal containers
65. Item in a diet used for the lowering of blood pressure
66. — bark (Erythophleum)
67. Border

DOWN

1. Contemporary American physician
2. Presently
3. Rhythmical cadence
4. Corpse
5. Insomnia
6. Wine vessels
7. ....icosis, pneumoconiosis
8. Pseudoleukemia
9. Smooth consonants
10. Head (comb. form)
11. Olfactory stimulant
12. Kidney (comb. form)
13. A common East Indian grass
21. Toper
23. Scabies
25. Receivers of stimuli
26. The quartan malarial parasite in its segmented phase
27. Ulcer (lat.)
28. German physician whose name is given to test for urine albumin
29. Fluid product of inflammation
31. Thin, discharge from a wound
32. Tenth cranial nerve
33. Irregularly notched
35. A luminary center of a system
36. Sesame
38. Incendiarism
39. Free
42. Eye-socket (gen.)
44. Divided into compartments
46. Dropsy
47. A nervous twitch
49. A birthmark
50. Boy's nickname
51. Cicatrix
52. Smooth, rounded protuberances
53. Fish sauce
54. New Guinea bay (poss.)
55. Compound of arsenegative element with hydrogen
56. Lyric poem set to
57. Scottish-Gaelic
60. Pounds (abbr.)

Mysteclin

STECLIN-MYCOSTATIN
SQUIBB TETRACYCLINE-NYSTATIN

WELL TOLERATED BROAD SPECTRUM ANTIBACTERIAL THERAPY PLUS ANTIFUNGAL PROPHYLAXIS

BROAD SPECTRUM ANTIBIOTIC THERAPY, EFFECTIVE IN MANY COMMON INFECTIONS

Because it contains Steclin (Squibb Tetracycline), MYSTECLIN is an effective therapeutic agent for most bacterial infections. When caused by tetracycline-susceptibile organisms, the following infections are a few of those which can be expected to respond to MYSTECLIN therapy:

bronchitis	gonorrhea	osteomyelitis	pyelonephritis
colitis	lymphadenitis	otitis media	sinusitis
furunculosis	meningitis	pneumonia	tonsillitis

MYSTECLIN is also indicated in certain viral infections and in amebic dysentery.

BROAD SPECTRUM ANTIBIOTIC THERAPY, WITH A MINIMUM OF SIDE EFFECTS

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Because it contains Mycostatin, the first safe antifungal antibiotic, MYSTECLIN effectively prevents the overgrowth of Candida albicans (monilia) frequently associated with the administration of ordinary broad spectrum antibiotics. This overgrowth may sometimes cause gastrointestinal distress, anal pruritus, vaginitis, and thrush; on occasion, it may have serious and even fatal consequences.

SQUIBB

Each MYSTECLIN capsule contains 250 mg. Steclin Hydrochloride and 250,000 units Mycostatin. *Minimum adult dose:* 1 capsule q.i.d. *Supply:* Bottles of 12 and 100.

Letters to the Editor

Radiologic Logic

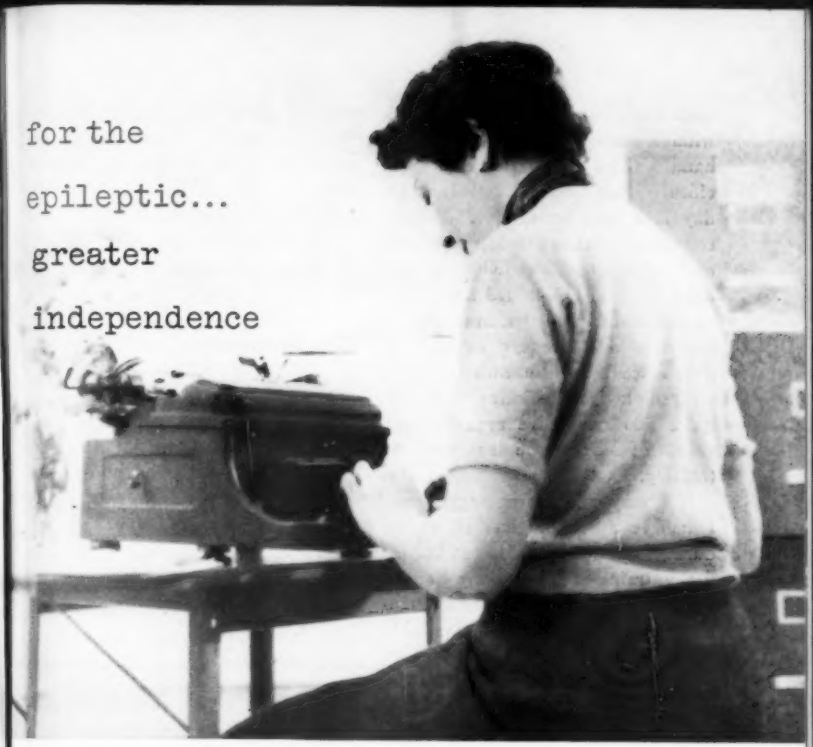
Congratulations on the new journal, which I think will serve as a good sounding board for exchange of ideas. The article in the first issue (Sept., 1955), Resident "Roundtable," is a very excellent type of article. Of course I was particularly interested in the section on radiology training.

The suggestion that there should be formal training in basic radiology requires definition of "basic radiology," to say nothing of the necessity for "formal training." It is my impression that basic radiology is taught at medical school, in an already crowded curriculum. It is, of course, very superficial coverage of the field of radiology and primarily the diagnostic part of radiology. I believe it could and probably should be more intensive during one's medical school years, considering the importance that it plays in the practice of medicine.

This is a difficult question to settle: How much radiology should be taught for the practicing physician to do an occasional x-ray in his office? Also, is it fair to the patient? The same argument applies to the practicing physician doing occasional surgery.

Another comment: "You have to be able to take and interpret x-rays. There are few radiologists that can sit back and tell the obstetrician positively that the female pelvis is going to be adequate for the delivery of a baby." I cannot help but ask that if the radiologist cannot sit back and tell the obstetrician that the female pelvis is going to be adequate, how in the world is the resident with a smattering of radiology going to be able to do the same thing.

It seems to me that the pendulum is now swinging too far in the other direction. In the desire to turn out well-rounded medical practitioners, which I think is commendable, we should not fail to recognize the limitations of time and capacity. We should know



Modern diagnostic methods and effective anticonvulsants now help the patient with epilepsy enjoy greater freedom from seizures. And with a more understanding society, greater independence is assured.

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an established anticonvulsant of choice, alone or in combination, for control of grand mal and psychomotor seizures -- without the handicap of somnolence.

DILANTIN Sodium is supplied in a variety of forms -- including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.

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what tools can be put to good use, without necessarily being able to handle them all ourselves. Specifically, the field of radiology today is a very broad one. A well rounded radiologist today is a general practitioner of radiology and he must have fairly detailed knowledge of practically all the branches of medicine and surgery in use today, since they lean rather heavily on radiological facilities. To acquire this knowledge requires long years of experience as well as training.

If I may add a few suggestions, I believe a lot of time is wasted during one's internship and residency training. The x-ray department of hospitals having such training programs is always available and it seems to me that they are not used frequently enough by the house staff. Although there might be little spare time in the house staff routine, there are nevertheless enough spare moments that could be used in the department of radiology, alongside the radiologist and technicians. Here, the kind of practical training that the article in question refers to could be very easily and painlessly obtained. It is my experience that where interns (assigned to emergency room and x-ray department as a combined service) take advantage of the radiologic service, they are far better off for it and end up by being able to interpret x-rays at least on a certain level. In addition, and what is more important, they learn what to expect from an x-ray department, how to use it, how to expedite matters by requesting examinations properly, etc., etc.

Joseph M. James, M. D.
Waterbury Hospital
Waterbury, Connecticut

Life Insurance

We struck oil in the mail department with our first insurance article. Since many insurance companies employing agents felt we had put agents in a poor light, we publish here a representative sample of their comments. Our thanks to the many residents who have indicated that this article was a timely one.

Those residents who have written us concerning specific insurance problems have already received personal replies.

We read with much interest your well-planned publication RESIDENT PHYSICIAN and wish to compliment you on an excellent projection for a group all too often overlooked.

It was of special interest to us that you saw fit, in your first issue, to include a discussion of family economics for the resident physician under the title, "What About Life Insurance?" This is encouraging, for so many technical publications overlook these basic elements in the planning of their reader audience.

This particular insurance article was a bit disconcerting to many in

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widely prescribed because of these important advantages:

1) rapid diffusion and penetration
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3) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
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in prolonged illness, prescribe

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TETRACYCLINE with STRESS FORMULA VITAMINS

Attacks the infection, bolsters the body's natural defense. Stress vitamin formula suggested by the National Research Council in *dry-filled, sealed* capsules with ACHROMYCIN, 250 mg. Also available: ACHROMYCIN SF ORAL SUSPENSION (Cherry Flavor), 125 mg. per 5 cc.

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(a Lederle exclusive!) for more rapid and complete absorption. No oils, no paste, tamperproof!

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*REG. U.S. PAT. OFF.

the field of life insurance because of its generally negative tone towards the army of agents serving the public, but at least it did carry a good solid discussion of certain life insurance fundamentals.

. . . . Again, congratulations on a fine start in a new field and success to you.

Chester C. Nash
Director, Life Insurance
Information
Press Division
Institute of Life Insurance
New York City, New York

Many Competent Men

This letter was addressed to Mr. Azoy, author of our insurance series.

A number of our agents are tearing their hair out by the roots over your article, "What About Life Insurance?" in the September RESIDENT PHYSICIAN, and have urged me to complain to the editor.

. . . . I suggest that, after all, you might have been a little hard on the many competent men who really have a professional attitude in pursuing their calling. Also I am afraid you convey the impression pretty clearly that life insurance should be bought over the counter and in no other way. Extended logically, this would also imply that the whole field of retailing and selling was a parasitic one and that everything should be bought direct from the manufacturer or, at least, from a warehouse.

Overzealous and even unscrupulous men can be found in any area of endeavor (not even banking is sacrosanct) and if you will reread your article, I think you may see perhaps that you have branded the whole field of life insurance selling as one which the buyer should beware. . . . It strikes me that in so doing, you have not performed a real service for the readers of RESIDENT PHYSICIAN.

We have a great many physicians who are very happy with the programs our competent agents have set up for them and I believe that they would be the first to admit that they could not have achieved such programs without the help of experienced and conscientious men.

David W. Tibbott
Director, Information Services
New England Mutual
Life Insurance Company
Boston 17, Massachusetts

We sincerely hope the resident reader did not get the impression that he should beware of the life insurance business or its competent agents. While concurring with Mr. Azoy that many sound policies can be obtained directly, without the use of agents, we are certain Mr. Azoy agrees with us that the life insurance agent is in a position to provide the resident with valuable advice and service. Perhaps Mr. Azoy's November and January insurance articles in RESIDENT PHYSICIAN *will straighten any misalignment of perspective on this point.*

Perrin H. Long, M.D.

Editor's Page

Education or Training?

THERE IS, we believe, a marked difference between training and education. The meaning of training can well be illustrated by a story which was recently told me by Dr. Edward D. Churchill, Chief Surgeon of the Massachusetts General Hospital and John Homans Professor of Surgery at Harvard:

* *

"Some years ago a friend of mine was going through some of the hospitals in an Asiatic country. They were staffed by 'doctors' whose training was about on a level of our high school graduates. They showed him a patient who was about to be discharged well, following cerebral spinal meningitis. My friend asked, 'How did you know he had cerebral spinal meningitis?'

'We did a lumbar puncture.'

'What did you do then?'

'We put some of the fluid in a hand centrifuge and made a smear preparation of the sediment. This was stained with a Gram stain and by comparing it with a picture in the book, we could see that it contained meningococcus.'

'Well, what did you do then?'

'We gave him sulfadiazine.'

→

"In other words, here was a series of technical steps which could be carried out by many high school boys almost with the same skills utilized to develop and print a roll of film. Have you ever stopped to analyze how much of our medical 'education' is simply training, geared to the attainment of sub-professional skills?"

* *

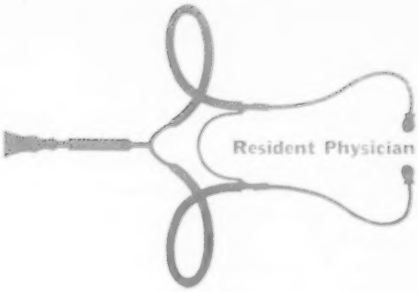
Possibly it would prove interesting if the reader would analyze the program of which he is a part to see how much of his time is devoted to acquiring "skills" or "techniques", and how much time is given over to the study of the natural history of illness, the social, moral and economic aspects of illness, to laboratory research, and to reading and contemplation on the problems which illness has brought to the world.

To acquire medical skills without achieving a broad understanding of illness and its problems, will limit the vision of the physician and reduce his practice of medicine to a sort of mechanical drudgery.

Comprehension, evaluation, reasoning, discernment, finesse, understanding, and judgment; these vital qualities of the physician can only be developed through sound residency *education*. Proficiency, competence, knack, and technical excellence result from *training* and repeated practice. Specific rigid training is best left to the plumber, carpenter or painter.

Medicine is not static; its objective is unlimited. We believe that residency programs based on educational values will provide the resident with the necessarily wide background needed to equip him to move forward in a science and an art which in itself has always been forward-moving.

Perrin H. Long.



Locating Your Practice

"WANTED — Surgeon, qualified or certified. Locate large Midwest city, established group."

You've probably seen a number of journal advertisements such as this. The specialty will differ. The place may be West Coast, Northeast, South or any of the 48 states or foreign countries. The point is that someone, somewhere, has indicated a need for a specialist. You may be it.

But before you would consider answering an ad for your specialty you first will have decided just about where you'd like to go into practice. And that, doctor, is a mighty big question.

A small number of residents have a situation ready-made and waiting for them upon completion of their residency. A happy thought, but rare—excluding, of course, obligated military service.

For the majority of residents, the location of their first practice is a questionmark. Although such alternatives as group or solo practice, industrial or private, are important, the question: "Where shall I begin my practice?" is probably the most urgent and worrisome one you must face. And the earlier you face it, the better.

Here's why: (1) You may properly wish to take a part of your resident training in a hospital located in the area of your future practice. (2) You have a good deal

of information to get together and perhaps a visit for a look-see before deciding.

Many residents find that a split residency—part spent in a famous-name teaching hospital, part in the local or "home" hospital—really pays off in training, local association, prestige, and later, a hospital connection.

Though many facts will have to come to you through the mail, a visit is a must if possible. (By getting it in during your vacation you'll save time.) So, with a little planning now, you can list yourself among the fortunate minority of residents who have an opening all lined up and waiting for them when they complete their residency.

You may have one important complicating factor in the way: Though perhaps not interested in a military career, you still may be obligated for some service with the armed forces. Possibly part of your residency will be spent in the service. Even so, you should get working now on a long-range plan for your future. In service or out, obligated or not, there are some basic steps you can take now to get rid of the uncertainty about the location of your civilian practice.

Near home or away?

A big map of the United States and a heavy crayon will get you started. After that you'll need some stationery for a few letters to line up opportunities, establish contacts, and get facts on the areas you've tentatively selected.

But first, do you want to locate near home or away?

Maybe you're not sure. Perhaps you've been away from home in the armed forces, probably during your residency—or while in medical school. In other words you're not afraid to go away from home. But think first, is there anyone else to consider?

If you're married, then of course there is someone else to consider, someone pretty important. Your wife is a big part of this decision. Get her thoughts. "I'll be glad to follow where ever your work takes you." That's what the loving wife murmurs in the movie script and, in your case, it may be true. Or, she may follow and then take the next train back, alone. Don't take a chance on being disenchanted.

So, ask your wife; as a full partner she'll come up with some sound ideas. Besides, it is always better and smarter to share your big decisions with those who must share your success or failure. That's why you got married in the first place, remember?

How about your parents and in-laws, do they come into it? Certainly. Kinfolk provide an important backstop, one which can be rather comforting in emergency or trouble. Chances are they'd like to be near enough to visit you—at least occasionally. If you're too far away, the expense, their age, and the time

involved will probably make visits rare.

So think carefully before you deny your future family a grandma and grandpa to visit. Incidentally, nearly everyone has "in-law trouble." It's generally something you can solve, or at least learn to live with. So make sure it's real big trouble before you pack up and hie yourself off to the other coast solely because of it.

But the most important thing is your future in medicine. You have your own life to live. Your family and her family should be the first to realize that. If your big opportunity happens to be out of town, go and get it. Air travel will make the trip back home only a matter of hours. Remember, opportunity, future growth, and perhaps increased income are sound reasons for your decision.

At home

Presumably, you've weighed the merits of your home town against moving into a new territory. If for one reason or another you've already decided that home is where your heart is, then your problem's down to workable size.

You'll know the hospitals, probably a number of physicians in practice, and can easily determine through personal talks the opportunities available.

If your father or other relative is established in medicine, you have an excellent entree of course. Going it alone is a commendable thing. But only when you really are alone. Don't make the mistake of not letting your father help you with his advice and the many valuable associations he's built up over the years. Keep in mind that no one worth considering will consider you're riding in on his reputation alone. Your ability will make or break you regardless of your personal relationships in the beginning. That's the way you want it. Every physician in town will know this. And equally important, most of your patients instinctively feel that especially because your father is a doctor, you'll try to be as good or better or die in the attempt.

True, you'll face the inevitable comparisons. But comparisons between young and old doctors in the same town are common even when no kinship is involved. If your specialty differs from your father's, the problem practically disappears.

And too, even without tinting your hair gray, you will still be able to build a practice on your merits as a physician; and without any reference to your record as substitute halfback on the high school football team.

Suggestion: Try for a period of residency at the hospital you'd like to work with. If it's a top teaching hospital, fine. If not, you will still build an invaluable relationship with the staff. This will go a long way over the years in helping your practice grow quickly. If accepted, re-

member, you'll be sized up in and out of the hospital and so you'll be extra sure to keep your nose clean in your personal as well as professional relationships.

Supposing you decide the home town just isn't for you. Now you're ready for the map and crayon. First "x" out those states and areas which don't interest you from strictly personal considerations. By eliminating those which aren't particularly attractive to you or your wife, you'll be surprised at how quickly your problem has been limited.

Next, again from your own feelings, draw a heavy line around those states which you think might be most desirable. You are ready now to analyze specific areas.

Population

You probably would like to practice in an area where population is expanding. The United States Bureau of Census has projected population growth ahead for the next ten years. Here's what they report:

1. Fastest growth is West and South. California will have more people than New York by 1965. Washington and Oregon also are adding new families at a rapid rate.

2. Nevada looks to be the fastest growing of all states with a gain of more than 40% expected by 1965. Arizona would be next in rate of growth with a gain of nearly 40%. In actual numbers however, these states are still sparsely populated. Florida, in ten years, will move from 15th spot to 10th in population rank. Texas will pass Ohio, move into 5th from 6th place. (In recent years actual growth has surpassed census bureau projections.)

3. The United States as a whole will add about 25 million new citizens in the next ten years. Outside of the West and South, Michigan, Maryland, Delaware, and Connecticut will each continue to grow at a faster rate than the country as a whole. (See chart on population expansion by states.)

4. New York, New Jersey, Pennsylvania, Illinois and Ohio will grow at about the average for the nation.

5. Population growth will be slower in New England, the Southeast, and South Central states and in the Northern Central and Middle Western farm states.

The trend is established: People are heading toward the milder climates of West and South. California is expected to grow more than three times as fast as New York over the next three years with Washington and Oregon nearly equaling this rate. The result is that in the next ten years, the West Coast will add nearly six million more people; equivalent to adding a city almost twice the size of Chicago. So much for population trends. Now what about city, rural, or suburban practice?

Rural

For many specialties, the strictly rural practice doesn't exist. Coun-

try towns? Yes. But size is a factor. With some knowledge of fees you can pretty well estimate in your particular specialty about how many cases it will take to keep you eating. True, any rural town will draw people from miles around. But how many miles? How far is the nearest hospital? How far is the nearest specialist in your field? If you are rural-minded, you should get the answers ahead of time.

Larger towns from 20,000 to 50,000 persons might be the minimum size for a "rural" specialist. Even here, remember that your practice probably won't be a wealthy one. The fact that farm income has dropped from 12% of national income in 1946 to 7.2% of national income in 1954 indicates the trend. Many of your patients won't be able to pay you promptly or well.

Farmers today are a big population group—some 21 million people living on farms (and about 31 million more in rural areas closely tied to the farm.) Though most farmers are much better off than before World War II, still their income last year was down 10% from the previous year.

One other fact points up the squeeze on farm people. The price which farmers must pay for their tools, seed, etc., has increased while the prices they get for their products has decreased steadily for the past eight years.

This doesn't mean that a rural practice is an unsatisfactory practice in any sense of the word. It merely indicates that income-wise, the average country specialist is not in a position to increase his income as readily as the city doctor.

In spite of this, perhaps your mind is made up. You would like to move into an average-size farm community. You want the many pleasant social relationships which physicians in these communities enjoy. And if that's what you want, don't settle for less.

When you're country inclined, a city practice can dull your enjoyment of living as well as your practice of medicine.

Some things good; some not so good

(1) A specialist often takes a rural practice as a challenge to accomplish something for those who really need his help. But hospital facilities are a big part of any specialty. You may find you're a long way from the base of your operations, consults, and lab facilities.

(2) Country people are friendly but very independent. What they "know" about their own medical affliction and its "proper" treatment will be kept to themselves. What you know and tell them about it may not be believed. Your instructions will sometimes be ignored. Since you may not realize that this is happening in any particular case, it will frequently be difficult for you to evaluate what you are actually accomplishing.

Where will YOU be ?

STATE	POPULATION NOW	POPULATION IN 1965	PERCENT GAIN
PACIFIC			
Wash.	2,611,000	3,171,000	21.4
Oreg.	1,705,000	2,145,000	25.8
Calif.	13,239,000	17,816,000	34.6 ✓
	5,578,000		
EAST NORTH CENTRAL			
Ohio	8,671,000	9,925,000	14.5
Ind.	4,285,000	4,905,000	14.5
Ill.	9,273,000	10,386,000	12.0
Mich.	7,176,000	8,536,000	19.0
Wis.	3,622,000	4,059,000	17.8
	4,677,000		
MIDDLE ATLANTIC			
N.Y.	15,667,000	17,456,000	11.4
N.J.	5,322,000	6,075,000	14.1
Pa.	10,890,000	11,850,000	8.8
	3,502,000		
SOUTH ATLANTIC			
Del.	377,000	457,000	21.2
Md.	2,662,000	3,067,000	19.0
D.C.	872,000	999,000	14.6
W. Va.	1,974,000	2,123,000	7.5
N.C.	4,328,000	4,881,000	12.8
S.C.	2,254,000	2,494,000	10.6
Ga.	3,476,000	4,045,000	10.0
Fla.	3,657,000	4,983,000	36.3 ✓
	2,762,000		
WEST SOUTH CENTRAL			
Ark.	1,931,000	2,018,000	4.5
La.	2,992,000	3,439,000	14.9
Okla.	2,324,000	2,396,000	4.0
Tex.	8,645,000	10,088,000	16.7
	2,069,000		

STATE	POPULATION NOW	POPULATION IN 1965	PERCENT GAIN
MOUNTAIN			
Mont.	625,000	671,000	7.4
Ida.	623,000	703,000	12.8
WYO.	316,000	357,000	13.0
Colo.	1,466,000	1,681,000	14.7
N. Mex.	797,000	962,000	20.7
Ariz.	1,022,000	1,424,000	39.3 ✓
Utah	769,000	912,000	18.6
Nev.	228,000	325,000	42.5 ✓
	1,189,000		
EAST SOUTH CENTRAL			
Ky.	3,027,000	3,279,000	8.3
Tenn.	3,437,000	3,885,000	13.0
Ala.	3,201,000	3,558,000	11.2
Miss.	2,212,000	2,383,000	7.2
	1,178,000		
WEST NORTH CENTRAL			
Minn.	3,127,000	3,431,000	9.7
Ia.	2,633,000	2,784,000	5.5
Mo.	4,183,000	4,538,000	8.5
N. Dak.	625,000	642,000	2.7
S. Dak.	665,000	696,000	4.7
Nebr.	1,365,000	1,437,000	5.3
Kans.	2,098,000	2,222,000	8.5
	1,117,000		
NEW ENGLAND			
Me.	930,000	996,000	7.1
N.H.	536,000	573,000	6.9
Vt.	382,000	404,000	5.8
Mass.	5,026,000	5,545,000	10.3
R.I.	836,000	916,000	9.6
Conn.	2,251,000	2,621,000	16.4
	994,000		

NUMERICAL GAIN

(3) You'll find you are in demand for civic committees, clubs, and so forth, almost from the beginning.

(4) Circumstances may force you more and more into general practice.

(5) Associations with other doctors, especially with men in your specialty, are often few and far between.

(6) Peace, it's wonderful! You will work hard and long to keep going but your recreation is in your backyard. Fishing, hunting, local bowling and other group sports, all are relaxing and usually available.

(7) Small town gossip is no easy thing to get used to. Your errors will be magnified and distorted through tongue-wagging. A thick skin is a pre-requisite for rural practice . . . especially if you're not a native of the area. It could take years to be "accepted."

(8) If you've got to have the top laboratories near you—if you can work only under the best possible conditions, don't be a pioneer in the wilderness. Face your requirements and you'll measure up more fully to your own abilities. While it may be true that "some of the best surgery is performed on kitchen tables" remember that not all the best surgeons accept the challenge of such conditions voluntarily.

City practice

Although all cities are not alike, most are alike in one respect. They're crowded. If you don't like being deep in hurrying humanity stay away from the big cities. If the hustle and bustle adds zest to your life, if crowds, fine theatres, museums, art centers, concerts, etc., are your interest, then city life, *big* city life is for you.

Professionally, a city offers many fine teaching and study advantages in the large municipal hospitals. But can you get in? Check first. City practice provides the welcome chance to compare notes with others of your specialty. This also means you can get a standby while on vacation. Big league baseball, football, hockey, basketball — and medicine, can be found in big cities. But the best medicine is no longer exclusively city property.

Competition is keen, established men have a big edge, naturally. But some of these physicians are moving to the suburbs, thus creating a few openings on hospital staffs and in practice opportunities.

Clinic work is an important part of municipal practice — but the smaller cities around the country are coming up with top facilities in this respect and modern air-conditioned hospitals under the Hill-Burton Act are being built everywhere. Cities of moderate size such as Columbus and Toledo, Ohio; Rochester and Syracuse, N. Y.; Worcester, Mass., Jacksonville, Fla., Denver, Colo., Sacramento, Calif., all have big city advantages yet offer living and practice opportunities far

less crowded than those in New York, Chicago, or Boston.

Suburbs

Sharing to some extent the advantages of city practice while getting away from many of its disadvantages are the suburbs.

According to a recent survey of Fortune magazine, suburbs are the fastest growing areas in the United States. In attempting to define "suburbs", one physician said: "Start going in any direction from Main Street — you'll know when you've hit the suburbs". And you will. The distance you must go out from "Main Street", of course, varies according to the size and shape of the city.

But all suburbs have: lots of young families; ranch, cape cod, and split-level houses; multiple-store shopping centers, and new schools too small for the growing community. These are the well known identifying marks of the average new suburban area.

But no matter how you may feel about suburbia, the fact is that suburban living is attracting more and more people. Most of these are convinced it is the ultimate in the way to live. Maybe you'll agree.

In the suburbs you can be close enough to the city to utilize most of its professional, cultural, and recreational advantages, yet be far enough away to breathe clean air and enjoy a little uncluttered sunshine as a steady diet.

In one Eastern suburban community, three physicians were in practice in 1951. This year there were 17. In the same period, population jumped from 2,000 to 18,000. The fact that many of these new arrivals to suburbia are young people is an advantage to the new physician. Getting acquainted is easy, there are no solid cliques formed, no walls to knock down. But often there are hospitals to build and schools that need immediate expansion. You may have to lead the civic parade for fund raising.

Many department stores from the city are grabbing up spots in the suburbs just to get in and established first. They evidently believe that the suburbs are going to be here to stay. You might draw the same conclusion and follow their example in locating your practice. Importantly, new medical groups are forming all the time, new clinics and group practice centers of modern design are springing up. Here might be your opportunity.

One disadvantage: "It will be difficult to determine whether or not your specialty is needed without going to see for yourself. The growth is so rapid that new openings are appearing all the time. But old ones are filled quickly so any information you may get through the mail might be outdated before you get to read it.

Getting some facts

Let's say that now you've got it narrowed down. Whether urban,

rural or suburban (you may not be sure) you at least have a few areas you'd like to look into. Start off with brief letters to the state and city chambers of commerce. Ask for any information they would have for you concerning climate, income groups, housing, schools, hospitals and so forth. Tell them you are considering establishing a home in the state. This is just general information to help you get a better idea of the state—not of practice opportunities—so you needn't mention that you are a physician.

The second step may be taken at the same time. Write to the state medical society, attention Physician's Placement Service (most societies have such a service), asking for any information they might have for a physician of your specialty seeking an opportunity. Don't send a long biography—just your specialty and whether you are board certified or qualified.

Now you're on your way to getting information.

In a subsequent article, we will discuss the "how" of locating; the steps in an orderly plan for getting and evaluating openings in your chosen area. Current estimates show that nearly 25,000 physicians change the location of their practice each year. Thus, your choice is not final. But your chances of sticking are much improved if you check the situation carefully before you move in. Start checking now.


JUN
MAY
APRIL

Obstetrics and Gynecology Board Requirements

Knowing exactly what's required often prevents confusion and costly misunderstandings. Here are essential facts for quick review. When your particular specialty appears, mark the cover and binding of the issue for ready reference.

The information contained in this article was obtained through direct correspondence with the specialty board. Current news such as changes in requirements, special announcements, and notices of date and place of examination will be published in *Resident Physician* as received from the various boards.

The American Board of Obstetrics and Gynecology was organized in 1930 by the combined efforts of the American Association of Obstetricians and Gynecologists and Abdominal Surgeons, the American Gynecological Society, and the Section on Obstetrics and Gynecology of the American Medical Association. Each branch elected three Fellows to constitute the American Board of Obstetrics and Gynecology. The Board held its first meeting in September, 1930, the year it was incorporated.

Purposes

In brief, the Board was set up to:

1. Raise standards and determine the competence of practitioners professing to be specialists in obstetrics and gynecology.

2. Control and conduct examinations for voluntary candidates and grant and issue specialist certificates in the field of obstetrics and gynecology.

3. Serve the public, hospitals, and medical schools by preparing lists of certified specialists.

Basic requirements

1. The Board will not accept applicants for examination who are not full citizens of the United States or of Canada, though they be residents of either country. Foreign born applicants must have been certified by either the National Board of Medical Examiners or licensed to practice medicine in the United States or Canada by a State or Provincial Board of Licensure. No-

tarized statements, *not* original citizenship papers, must be furnished when the application is filed attesting to the fact of full citizenship in the United States or Canada, if the applicant is foreign born. Further, there is a required probationary period of at least three years from the date of licensure in the practice of medicine in these countries before such a candidate may be admitted to examination.

2. A degree in medicine approved by the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association.

3. Establish that he is of high ethical standards and professional standing, licensed to practice medicine.

4. Make application for investigation of his credentials and character.

5. Limit his practice to obstetrics and/or gynecology—and must have done so for two years following residency and prior to application.

6. Have completed medical school eight years prior to date of application.

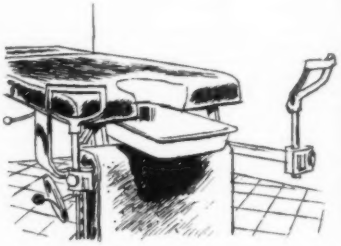
7. Must relinquish certification by any other board before being certified in obstetrics and gynecology.

Special requirements

1. Complete at least one year of approved internship. The general rotating type is preferred though not mandatory.

2. Three years of residency training in obstetrics and gynecology in an approved hospital or adequate preceptor training. Of the three years, he should receive at least one year in either obstetrics or gynecology, and two years in the other.

3. Two years of post-training practice limited to his specialty. This may include full time medical school or hospital positions, private



practice or as an assistant or associate. It can not be satisfied by an additional period of residency.

4. Graduate courses are not required and if taken will be given no more than six months credit. Fellowships will be evaluated individually.

5. Preceptorships. The Board will not accept training solely by preceptorship. *A minimum of one year formal residency is required.*

Any candidate who applies for preceptor training must notify the Secretary of the Board of his intentions and give the name of his preceptor. The preceptor must also notify the Secretary of his hospital affiliations, clinical material, oppor-

tunities for studies, and proposed program. Each program will be *reviewed in advance* for approval or disapproval and will be reviewed periodically.

As a rule, each year of preceptor training will be equivalent to six months toward the three years of formal training required. (See 5, above.)

Military service

Preceptor credit is given if the physician is working in a service hospital in an obstetrical-gynecological service, and if the departments are supervised by diplomates of the Board or recognized obstetrician–gynecologists. *If the hospital is officially approved for residency in obstetrics and gynecology, he may obtain full residency credit.*

Application and fees

The application fee is $25 and is not returnable. A special application form is provided by the Secretary's office. If the candidate is claiming preceptor credit there is a special form to be used. If the candidate is not sure of his eligibility, his credentials may be evaluated by submitting a special form. There is a clerical fee of $15 for this service.

Any applicant declared ineligible must wait for a period of two years before requesting reopening. No additional fee is necessary if reopening is requested by the second year. If the candidate is notified that he is eligible to write the examination, an examination fee of $100 is required. This is not returnable.

List of patients

On applying for admission to examination, a plain typewritten list of all patients admitted to the hospital where they practice (for the year preceding their application) is required and must accompany the application. This should include the diagnosis, pathological diagnosis, nature of treatment, and end result.

Case reports

When the candidate is notified by the Secretary that he is eligible, 20 condensed case reports are required. If unilateral certification is applied for, the cases must all be from the branch applied for. The exact method of preparing these case condensations is outlined in a bulletin published by the Board.

Examination

The examination is given in two parts. Part I is given annually in February. Part I consists of a written examination and a review of case reports. It is held in any convenient city where there is a diplomate of the Board to conduct the examination. No grade is given; the result is "pass" or "fail." The examination consists of a comprehensive written examination which is limited to a maximum of three hours. It is possible to pass the written exam and not the review of

case reports, and vice versa. If so, one can be re-examined in Part I after one year but within three years without additional fee.

Part II is conducted by the entire Board, and is usually near the time and place of the annual meeting of one or more of the national societies represented on this Board. It consists of two parts:

a) An oral examination before one or more examiners.

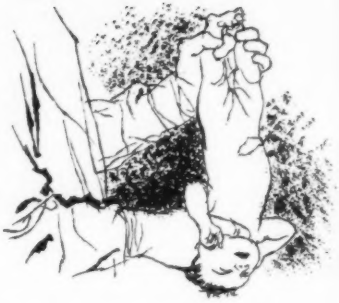
b) Pathology examination.

The examiners meet and review the applicant, and pass or fail the candidate by joint action of the Board.

If a candidate fails Part II, he is not required to repeat Part I. He may be re-examined in Part II within three years without formal application and with a re-examination charge of $25.

Certificates

After successfully completing Part II, the candidate will be issued a certificate by the Board. This in itself does not confer any degree or legal qualifications. Its chief purpose is to standardize qualification for specialists in obstetrics and gynecology.



Further information

Information may be obtained by writing to: Robert L. Faulkner, M.D., Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Rd., Cleveland 6, Ohio.

Next examination

The next scheduled examination (Part I, written examination and review of case histories) will be held in various cities of the United States, Canada, and in military centers outside the continental United States, on Friday, February 3, 1956. A total of 20 Case Abstracts are to be sent by the candidate to the Secretary as soon as possible after receiving notice of eligibility to the Part I examination.

Calling All Residents

To be certain you won't miss a single copy of RESIDENT PHYSICIAN, please notify us *at least 30 days in advance* of any change in your *hospital* mailing address. Simply drop a card to RESIDENT PHYSICIAN, 676 Northern Blvd., Great Neck, N. Y. *Please state both old hospital and new hospital addresses,* your specialty, and the name of your chief of service.

Money to Start Your Practice

After a long period of education and postgraduate training at a relatively small stipend, most residents haven't been able to save any significant amount of cash or assets.

In fact, a large number are in debt to parents, relatives, or friends as a result of a long and costly period of medical training.

Yet, all residents are perfectly aware that it takes a good deal of money to establish a practice. Starting from scratch requires cash to pay for such things as equipment, instruments, office rent, and probably most important, actual living expenses while waiting for a practice to grow. Most haven't the vaguest idea of where the money will come from.

And that is no small problem.

As a resident, you may take a measure of comfort in the fact that the vast majority of specialists, now in successful practice, at one time faced the same problem.

Somehow, all managed to solve it.

With their experience as your guide, plus a little planning on your part, you will solve it too.

The bright side of the picture is that you're actually in a good spot. As a resident-in-training, few lenders want any part of you. But, as a graduating product of specialty training, lending agencies consider you a "good risk."

And why not? You have not only proven your ability and character by sticking to your specialty training, you have also reached a rather select pinnacle in earnings potential.

This alone doesn't make the lender dig into his pocket to get you a few thousand, but it helps.

Credit rating

You can borrow money to start your practice if your financial house is in order — on the surface at least. In other words, if your *credit rating* isn't fouled up, you can approach most banks with a fair degree of confidence that you'll get a loan.

A credit rating is simply your past record of borrowing and paying back; how much and how promptly.

Perhaps you don't have one. If you've never bought anything on time, always considered it a bit

shocking to purchase anything on the installment plan; if you always pay cash for everything, you probably don't have a credit rating.

But that doesn't mean you can't borrow money. No credit rating is at least somewhat better than a poor credit rating.

What does the lender want to know? Any lending institution will ask you, usually on your loan application form, your income, estimated expenses, your outstanding debts, life insurance premiums and other fixed expenses. Your answers to these questions help the lender determine whether you have enough unobligated income each month to pay off the installments on the loan for which you are now applying.

However, as a resident, you have very little for any lender to go on. But there is one thing on which most of the larger banks throughout the United States are agreed: The record of loans made to physicians (they call it "loan experience"), is excellent. In other words, your brother physicians who have gone before you to borrow money have, almost without exception, paid back promptly and fully.

That's in your favor. In fact it may be the difference between your getting a loan and drawing a flat turn-down.

Monthly payments

The usual method of repayment for any loan is in monthly installments. Unfortunately, the first one is due right away. It is almost impossible to find any lender who will defer payments for five or six months. This can be rough on you if you go in over your head.

For the average wage earner, the monthly payback, beginning at the time of the loan, is fine. A salaried person can easily determine from his budget just how much he can afford to pay back each week or each month. But the physician just starting out faces a number of unknowns.

"Say *when.*"

And certainly not the least important is: How much will I be able to make the first month? The second month? The first year? You may know that at sometime in the future you will be earning a good income. But just exactly *when* is rather difficult to pin down. In other words, since your first months can be mighty lean ones, the need to re-pay a loan in big installments during this period would certainly add considerably to your problems. Keep this in mind when you are calculating your monthly payments prior to taking a loan.

Big banks

How would you go about getting a loan from a bank? Well, if it's a big bank and well-known for its liberal loan policies, such as the First National City Bank or Chase Manhattan Bank in New York City, you probably won't have much trouble.

Large lending banks have lots of experience. They know through their own statistics (and that's what they go by) that you will pay them back. They also offer the added advantage of having comparatively low interest rates, usually just under 6% simple interest annually on the unpaid balance. Period of the loan may be up to five years.

It's a good idea to call the bank first, arrange for an appointment, and then sit down with one of the executives and discuss the entire problem. Be confident and candid. Of course you will have previously figured out how much you need for equipment, rent, and so forth for your first year in practice. You also better include a figure under "working capital." This will include everything from living expenses to a reserve amount of money set aside to pay back the first five or six installments of the loan (this is important).

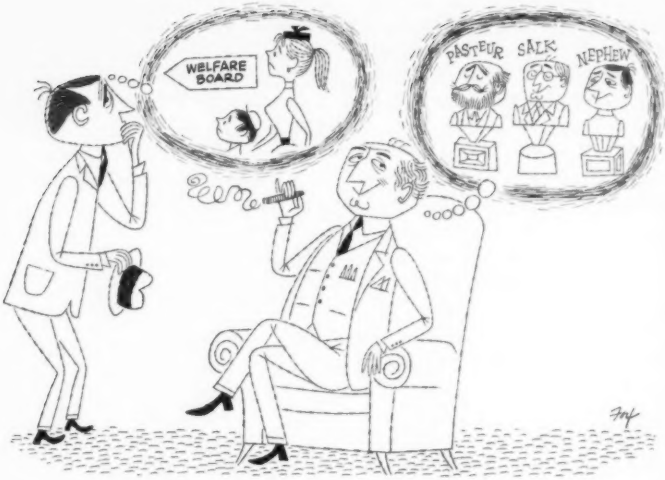
Bank policy

The executive with whom you talk will explain the policy of the bank in granting loans for business purposes. He will probably tell you that under the G.I. bill (if you are eligible) you can borrow up to a maximum of $13,333.33. You won't need anywhere near that much, however. Together, you will go over your list of estimated expenses.

The executive will ask you how long you'll want to repay. Now is *not* the moment to get courageous or proud. You'll want as long as you can have. It's good to stretch the loan out as far as the bank will permit (usually four to five years is tops). This will lessen your monthly payment with only a slight increase in the overall cost of the loan.

Example of rates

One bank in the East which does a big loan business offers special terms to ex-G. I. physicians. For example, if you want about $4,000 at a low rate of interest, such as 5.7%, your payments would be $121.15 a month for 36 months.



Your rich uncle may help you out . . .

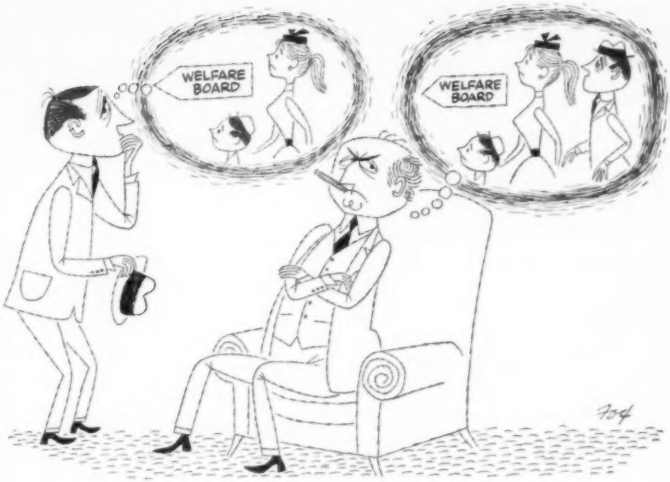
At the end of three years, you will have paid back $4,361.40. This is about as cheap as borrowing money can get. Other banks offer loans on a basis almost as liberal.

Of this $4,000, the bank will expect you to spend about $3,000 on equipment and perhaps about $1,000 as your working capital. The bank also takes a mortgage on the equipment you buy. That gives them a lien on your property. Thus if you fail (you won't) and can't meet the payments, the bank will recover a part of the loan made to you.

Co-signer

The only way to find out if the banks in your area will provide you with a loan similar to that described is to write them a letter, explain the problem in detail, and ask them if they would consider your application for a business loan of that kind. Be sure to mention whether or not you are eligible under the G.I. loan program.

In the event you don't seem to measure up to your bank's idea of a borrower, suggest that you have a "co-signer" or "partial guarantor". This simply means that although you are the borrower, someone else whom you know must agree to put his name to the loan note. It goes without saying that this individual should be pretty well fixed either in assets or income or both.



. . . then, again, he may not.

For example, if you don't want to borrow directly from your rich uncle for personal reasons, and yet the bank won't lend you money on your own signature, the solution might be to ask your uncle to sign your note. You will find most relatives are willing to go along with this (if only because to refuse would make them look bad).

So much for the banks. There is little need to discuss finance outfits since many have interest rates as high as 30% to 50%. However, federal savings and loan associations may offer you an excellent loan plan.

Medical supply house

Many medical supply houses have arrangements with loan agencies. A physician will buy equipment from a supply house and the supply house will then obtain a loan for the physician from a loan organization. The supply house will be paid immediately in cash and the physician then is indebted to the loan organization. Here again, interest rates vary somewhat from bank rates discussed.

Occasionally, however, special arrangement can be made with the supply house. Owners of such establishments often fully understand the needs of young residents. They would like to help you and at the same time keep in your good graces since they would appreciate your continuing business over the next 20

or 30 years. Often an extremely satisfactory arrangement can be worked out in this manner.

Insurance loans

It is doubtful that many residents have an amount and kind of insurance on which they could borrow to finance their opening practice. But one benefit of an insurance loan is that no security must be given and

no time limit is made. The loan is usually repayable in one lump sum.

One disadvantage is that for the duration of the loan, the value of the insurance policy is depleted by the amount of the loan. If this is of concern to the resident he can always take out a term policy for the amount that his original insurance becomes devalued, carrying it until he is able to pay back his original insurance loan.

If you happen to be lucky enough to get your start from your parents or relatives, remember to put whatever you borrow on a business basis. It will cost you little effort to draw up a note setting forth the amount and terms of repayment. But you will avoid those misunderstandings which very often crop up three or four years from the time the loan was made.

How much?

The amount which you may need to borrow will, of course, vary with your location, your specialty and your present financial circumstances. Generally speaking, your practice will take from $2,500 to $5,000. Again, make sure you have carefully estimated your equipment needs and expenditures for the first twelve months of your practice. Include car expenses and both a reserve for emergencies and for repayments of the loan for five or six months.

All bankers love to see something organized and on paper. Whatever you do, don't undercut yourself to the point where you start practice without necessary equipment.

Finally, keep in mind that you should have no embarrassment about borrowing money. This is an investment in your future. So, don't let false pride stand in the way of getting a proper start. (Did you know that approximately half of all clothing, furniture, appliances and automobiles, and more than half of all the homes purchased each year in the United States are bought on borrowed money?)

Start thinking now about how

much you will need. Make a list of possible sources. And, if you have a chance, start getting your credit rating established.

There's lots of money around to help you start in practice.

All you have to do is ask.

Grants to help you get started in practice are being made available by certain groups such as corporations and local medical societies on an easy pay-back basis at low interest rates. A round-up of loans will be included in a coming article.

Baltimore Residents Only!

Firefly-derived luciferin is being used in studies at Johns-Hopkins University. The substance, in combination, can be measured photoelectrically in gauging the amount of adenosine triphosphate (ATP) in plant and animal tissue (was recently used in determining the effect of the mental drug chlorpromazine on ATP in the central nervous system of rats).

To help get sufficient amounts of this firefly juice, the university is paying 25 cents for every 100 fireflies (delivered alive) and is giving a special $10 bonus to the Baltimore child who grabs off the most fireflies during the season.

Residents may feel that they would be interfering with a healthy outdoor occupation of happy little children if they were to muscle in on the business of firefly snatching. But looked at in one way, you'd be doing these kiddies a real service.

1. Kiddies can fall over things at night and get hurted bad.

2. Kiddies who become bored with firefly chasing might move on to bigger game (thus interfering with YOU).

3. Night-prowling youngsters of tonight are the delinquents of tomorrow morning.

So pick up your nets (don't look at us that way!) and get going—on second thought, better forget it. After all, if you get picked up for a peeping tom, the explanation that you were simply "chasing fireflies for Johns Hopkins" might not go over too well with the authorities—even if it was true. Besides it would take 2,000 fireflies to get a $5 bill. There must be a better way to spend an evening off duty.

By Major General Leonard D. Heaton, M.D.

Guest Editorial

Major General Leonard D. Heaton
Commanding General, Walter Reed Army Medical Center, Washington, D. C.

The teaching of medicine has evolved progressively through the centuries from the simple preceptorship to the complex curriculum of the modern university, and the ever-widening horizons in our profession make the selection of a hospital, or system of hospitals, for training of utmost importance.

Today, a young physician is confronted with numerous attractive opportunities from which he must make his choice. The progressive changes in the field of modern medical science usually entice the young physician to continue along such selected lines of specialty training as surgery, medicine, and in the laboratory and research fields. In this type of training, you have opportunities offered by excellent university hospitals, Federal hospitals, and well-staffed private and public institutions. You also have offers from good to mediocre institutions where your labor is sorely needed and the teaching you receive is limited. A young physician, therefore, must be careful in the selection of his training institution.

Behind me are 28 years of soul-satisfying practice in the Medical Department of the United States Army — years of experience that I treasure deeply and which I believe would be difficult for me to duplicate. I say this with utmost sincerity and honesty. Accordingly, I believe it would be worth your while as young physicians to consider the opportunities of an Army hospital's training program. Carried on in an atmosphere free from political bias, unhampered by economic pressures, and devoid of tense and damaging interpersonal struggles, the opportunities are limitless with wide areas of choice offered in any specialty. The teaching is unfettered and the personal desires and abilities of each

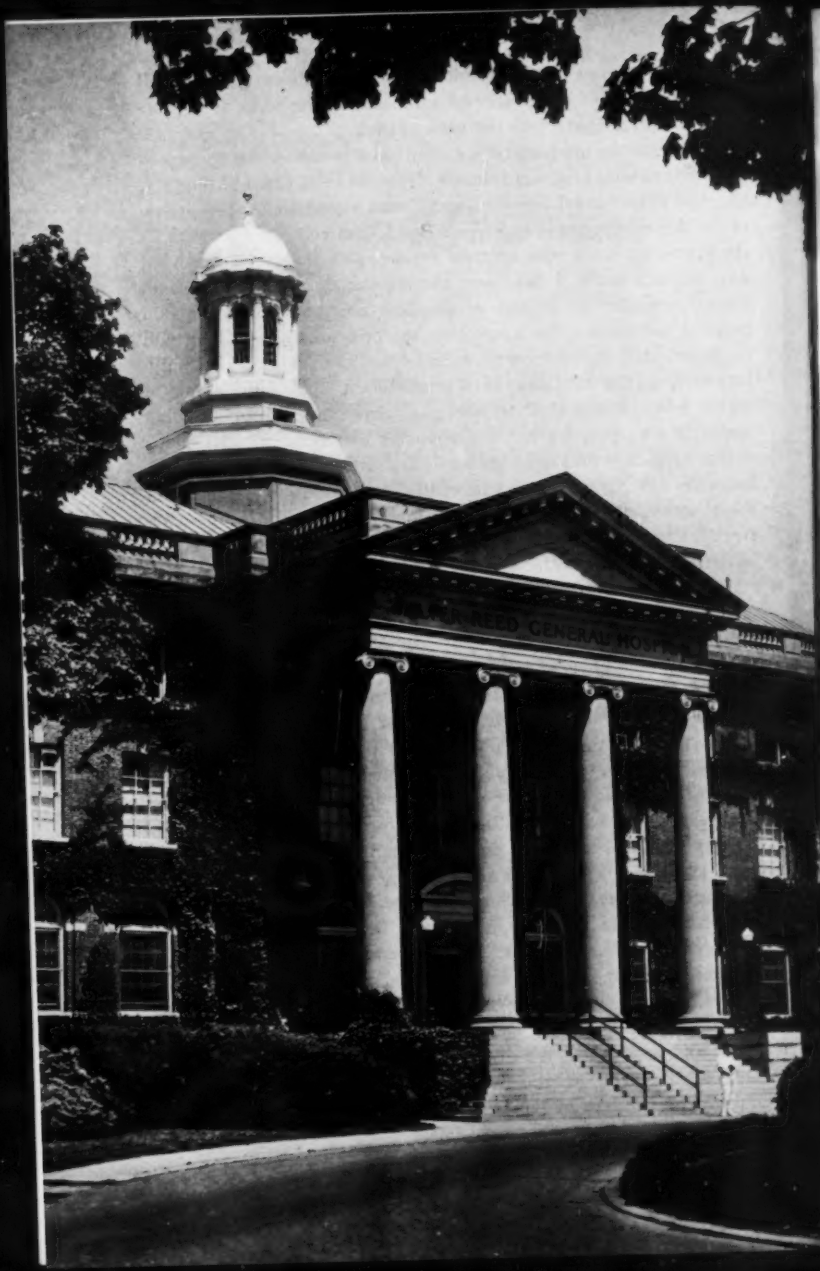
resident are given every attention. I can truthfully testify to all of this because of my continued intimate participation as a practicing surgeon right up to the present time.

I have had the unique privilege and good fortune to be connected with the training program from its inception — as Chief of Surgery, Chief of Professional Services, and Commanding General — at two of the Army's large general hospitals. I have continued to work in the operating room with surgical residents on regularly scheduled days of each week. I have seen the training program mature into what I consider to be one of the best postgraduate systems in medical specialties. To insure that the best possible training will be given, staff members with unusual achievements in both military and civilian medicine have been chosen. All of the chiefs of major services and most of the staff physicians in our teaching hospitals are specialty board diplomates in their respective fields

Our residency programs are so designed that they afford a challenge to the physician who is willing to devote his wisdom and social consciousness with humility and compassion to the constructive purposes of all mankind. At the same time they test his initiative and resourcefulness in pursuing the science of his specialty. Our hospitals have clinical material from all parts of the globe, presenting a scope and diversity rarely seen in other institutions.

The presence of good teaching facilities, supported by an institution dedicated to research, the help of fine local medical libraries in each hospital, and the advice of good hospital and consultant staffs stimulates the young physician to think, to go beyond the expected routine, and to pursue selected problems in greater detail. Our residents receive every encouragement in their fields of investigation, whether it be clinical or original research.

Army hospitals with such motivated staffs are not standing still. They are dynamic and constantly progressing. They show the spirit and courage of men who are respected for their professional achievements, and who love and believe in the high honor of our military medical institutions. The only motivating factor behind the success of our hospitals and the accomplishments of our teaching programs and medical research is the simple fact that we are working hopefully toward making greater contributions to human health and happiness. We desire young physicians who are interested in the good practice of medicine and research and who consider the welfare of the patient — his treatment, his care, and his cure — their primary and ultimate goal.



Walter Reed Army Medical Center

Third of a series on resident centers

Of the five Army residency training centers in the U.S. and Hawaii, Washington's Walter Reed Army Medical Center is probably the best-known. Its 1350-bed Walter Reed Army Hospital has been synonymous with the best in military medicine and surgery for nearly 50 years.

Whether Air Force bomber pilot or foot soldier in the Infantry, the military man speaks of "Walter Reed" with respect. And this respect was earned the hard way: top performance in the face of often tremendous odds, odds which are a product of war and further complicated by the thousands of miles separating field hospitals from "stateside" medical care.

Components

Besides treating many of the more difficult and unusual medical and surgical cases of the Army and Air Force through its Hospital component, the Walter Reed Center includes the Army's Institute of Research, Dental Laboratory, and the Prosthetics Laboratory.

The Army Institute of Research spearheads the army's medical, dental, and veterinary research and graduate education programs. Here too is the country's oldest school of preventive medicine, a pioneer in many public health improvements. Its medical teams have been engaged in research in all parts of the world including, most recently, the battlefields of Korea.

The Army Prosthetics Research Laboratory was established in June 1945. It has gained world-wide professional recognition for outstanding research in the development of artificial hands, arms, feet, and legs. Among its long list of credits is the interchangeable, artificial hand and hand hook, and a cosmetic glove which covers the artificial hand.

The Army Central Dental Laboratory became a component in 1947.

Keeping busy

The Walter Reed Army Hospital, around which the Center was formed in 1923, was founded in 1909 in honor of Major Walter Reed, the Army doctor who led in the fight and victory over yellow fever. Since its doors were first opened, the hospital has cared for more than 365,000 bedpatients among Army and Air Force personnel and their dependents. Last year it admitted upwards of 13,000 patients, with an average daily adult census close to 1200. And since the maternity ward produces a new Army recruit every four hours (that's an *average*, not a schedule), its 40 bassinets are kept busy, too.

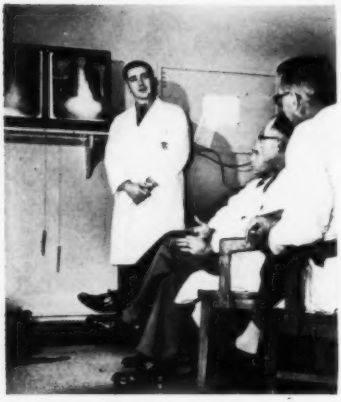
With its excellent staff and the newest in equipment, physicians from all parts of the world have come to observe Walter Reed's methods and take advantage of its well-known teaching programs.

Location

The Center's headquarters is on the original site of Walter Reed Hospital in northwest Washington, D. C., near the Maryland state border. The Graduate School, Dental Laboratory, and Walter Reed Army Hospital are also located here.

Photographs courtesy Signal Corps Photograph
Laboratory, Walter Reed Army Medical Cent

Walter Reed Army Medical Center.
Foreground: Walter Reed Hospital, an important
unit in the Army's extensive resident and intern training programs.



Resident present case, learns from the comments and discussion which follows.

A suburban section at nearby Forest Glen, Md., houses the hospital's ambulatory center, the Prosthetics Research Laboratory, the Army's first School for Practical Nursing, and the Army Audiology and Speech Correction Center. The third section, a housing development for enlisted duty personnel, is in Glenhaven, Md.

Residencies and internships

The Walter Reed residency training program embraces 20 medical and surgical specialties and subspecialties. All are board approved and meet the requirements outlined by the Council on Medical Education and Hospitals.

The intern training program consists of a rotating internship with three months each in internal medicine and surgery, and two months each in obstetrics and gynecology, pediatrics, and the medical specialty of the intern's choice. Walter Reed is one of ten Army intern centers.

Professional staff

The professional staff of Walter Reed Army Hospital consists of an assigned staff, an attending staff of civilian physicians and surgeons, and a house staff of student officers (residents and interns).

Assigned staff is composed of Medical Corps officers holding positions of chief or assistant chief of services or sections. They are primarily responsible for the teaching program for residents and interns serving under them and for other officers serving on duty status.

Attending staff is made up of civilian physicians and surgeons, diplomates of American specialty boards or having equivalent training and experience, and in practice in the vicinity of hospital. They are responsible for a definite part of the teaching program. Every effort is made to secure a minimum of 15 hours of teaching per week by assigned and attending staff members in each service or section participating in the program.

House staff includes:

Chief Resident. Appointed by the Hospital Commander from the group of third or fourth year residents assigned to medical, surgical, neuropsychiatric, laboratory, physical medicine, and radiologic services.

The assignment may be rotated among residents, with responsibilities according to capabilities. It is the chief resident's duty to plan and supervise meetings and conferences.

Fourth Year Residents. Completed three years of formal specialty training approved by Council of Medical Education and Hospitals of American Medical Association and are in fourth year of such training.

Third Year Residents, Second Year Residents, First Year Residents. Have two, one, or in first year of resident training.

Interns. Graduates of school or college of medicine approved by Council on Medical Education and Hospitals and in their first year of graduate training.

Duties and responsibilities

First year. The first year resident supervises work of interns serving under him, checks histories and physical examinations performed by interns. If no intern is available, he will take the original history and perform an admission physical examination. He is responsible for laboratory and clinical diagnostic work-up of patients under his care and visits patients under his supervision once daily at least. He is also responsible for progress notes on clinical records as well as the comprehensive final summary of patient's hospital stay. Generally, a first year resident has responsibility for one ward and is assisted by one or more interns depending upon number of patients, rate of turnover, and amount of patient care required. He is responsible for teaching interns and nurses in accordance with his capabilities.

Second year. The second year resident supervises work of first

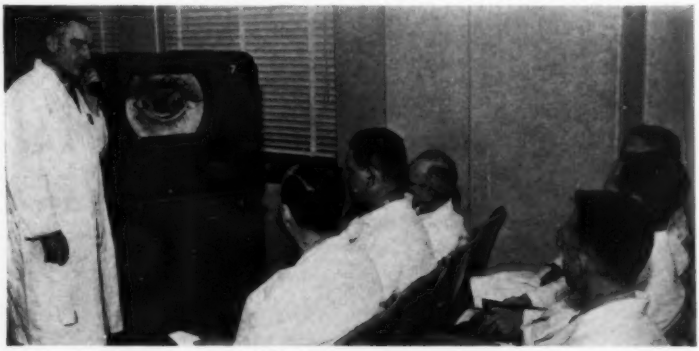
Walter Reed resident relaxes with his family in quarters provided on the post.

year residents and interns. He visits all patients under his supervision within 48 hours after admission, thoroughly studying history, physical examination, and work-up of patient, and adds admission note to clinical record. He sees all emergency cases at the earliest possible time, and as often thereafter as indicated. The second year resident directs and supervises the more complicated forms of treatment. He makes daily ward rounds, accompanied by first year residents and interns assigned to the ward and is responsible for suitable progress notes. He secures consultations from third or fourth year residents and other members of the assigned and attending staff.

In association with a third or fourth year resident, the second year resident may make consultations on services or sections other than his own for the purpose of accepting patients for transfer to his service. He makes final disposition of patients in accordance with existing policies. He assumes responsibility for teaching first year residents and interns according to his capabilities. He may select and pursue a research project under supervision of the chief of service or section concerned.

Third year. Where applicable, the third year resident will have general supervision of the service or section in which he is being trained. In this year, he completes the research project started in the second year, coordinates the teaching program of his section or service, participates in teaching of interns and residents, renders consultations, coordinates consultations from services other than his own.

Fourth year. General supervision



Color TV on a closed circuit brings eye surgery, being performed at Walter Reed Hospital, to residents and staff officers in Institute of Research classroom.

of service under guidance of chief of service. Serves as chief resident on rotating basis with other fourth year residents. Continues many of third year activities.

Ward rounds

Teaching ward rounds are conducted by qualified members of the staff on each ward concerned with a training program. Members of the house staff are called upon to present for group discussions those cases for which they are responsible. The instructor guides the discussion and points out the significant features of the work-up, differential diagnosis, treatment, prognosis, and disposition of each case. The residents have an opportunity to develop their teaching ability as they participate in the teaching of the interns.

Conferences

Walter Reed has a "required" conference schedule. Attendance at weekly clinical pathological conferences and bimonthly tumor clinics is mandatory. Professional staff conferences are a monthly requirement. Monthly conferences, devoted to military medical problems, are conducted by individuals whose background and personal experience in one of these fields are outstanding. Weekly conferences are sponsored by individual services, attendance at which is mandatory for the residents of the service concerned, and optional for other residents.

Studies in the allied sciences are

A well-stocked medical library is available to medical officers at Walter Reed.

effected by direct application of the principles in relation to clinical cases discussed at the bedside during ward rounds. In addition, didactic material is presented when indicated. Selected residents are given the opportunity to attend established full-time basic science courses, during, or at the completion of their formal training. For example, an affiliation between Walter Reed Army Hospital and Georgetown University for the residents in dermatology provides these residents with work leading to an advanced academic degree.

Research project

In the second year of formal training, each resident is encouraged to interest himself in a research project related to his specialty. His chief of service guides and advises the resident in regard to the selection of his project, as well as in its plan-

A golf course for military personnel is utilized by residents at Walter Reed.

ning and execution. The Hospital Education Committee has final approval of the research project selected. A project may be a matter of joint effort if there appears to be value in such a procedure. When the research project is completed, the responsible individual or group is encouraged to submit a report for publication in an appropriate professional journal.

Information on approved residencies, length of approved programs, and stipend for Walter Reed residents is listed on page 63.

On Dr. Lettsom, by Himself

When people's ill, they comes to I,
I physics, bleeds, and sweats 'em;
Sometimes they live, sometimes they die.
What's that to I? I lets 'em

—John Coakley Lettsom, M.D.—circa 1890

Army Residencies

Current facts concerning residency opportunities in the U.S. Army Medical Service Corps

At the present time, the Army has more than 300 resident positions divided among 22 specialties and subspecialties with programs conducted at five Army teaching hospitals. All residencies are approved by their respective specialty boards.

Commissioned officer

With rare exceptions, all Army residency appointments are based on the resident accepting a Regular Army commissioned officer status. Since acceptance of such a commission requires a *minimum of three years' service*, the army residency *fulfills any draft obligation on the part of a resident.*

Other requirements

The candidate for Army residency training must:

1. Be a citizen of the United States.
2. A graduate of a medical school acceptable to the Surgeon General.
3. Be physically qualified.

Obligated service

Since the primary purpose of the Army's residency program is to meet the Army's continuing requirements for competent specialists, the Army requires one additional year of service for each year of formal Army residency training.

However, the Army encourages the resident, when he has completed his residency training, to fulfill board requirements for practice. After completion of formal residency training, the resident is then assigned to another hospital where he can accrue credit with supervised practice time.

Pay and allowances

An Army resident is paid full salary according to his rank, plus allowances and other perquisites due a Regular Army officer. In addition, he receives the $100 per month incentive pay.

The resident is promoted exactly the same as any other Regular Army

Army Residency Programs.....a

1 Allergy
1 year of residency
1 residency — WALTER REED

2 Anesthesiology
3 years of residency
12 residencies — BROOKE, FITZSIMONS, LETTERMAN, and WALTER REED

3 Cardiovascular Disease
1 year of residency
3 residencies — BROOKE, FITZSIMONS, LETTERMAN, and WALTER REED

4 Dermatology
3 years of residency
11 residencies — BROOKE and WALTER REED

5 Gastroenterology
1 year of residency
2 residencies — BROOKE, LETTERMAN, or WALTER REED

6 Internal Medicine
3 years of residency
56 residencies — BROOKE, FITZSIMONS, LETTERMAN, WALTER REED and TRIPLER

7 Neurology
3 years of residency
7 residencies—LETTERMAN and WALTER REED

8 Neurological Surgery
4 years of residency
5 residencies — WALTER REED

9 Obstetrics & Gynecology
3 years of residency
23 residencies — BROOKE, FITZSIMONS, LETTERMAN, WALTER REED, and TRIPLER

10 Ophthalmology
3 years of residency
10residencies — BROOKE, LETTERMAN, and WALTER REED

11 Orthopedic Surgery
4 years of residency
29 residencies — BROOKE, FITZSIMONS, LETTERMAN, and WALTER REED

12 Otolaryngology
3 years of residency
10 residencies — BROOKE, LETTERMAN, and WALTER REED

13 Pathology
4 years of residency
24 residencies — BROOKE, FITZSIMONS, LETTERMAN, and WALTER REED

14 Pediatrics
2 years of residency
12 residencies — BROOKE, FITZSIMONS, LETTERMAN, and WALTER REED

15 Physical Medicine and Rehabilitation
3 years of residency
7 residencies — FITZSIMONS, LETTERMAN, and WALTER REED

16 Plastic Surgery
4 years of residency
2 residencies — BROOKE

17 Psychiatry
3 years of residency
7 residencies — LETTERMAN and WALTER REED

18 Pulmonary Diseases
1 year of residency
10 residencies — FITZSIMONS

19 Radiology
3 years of residency
19 *residencies* — BROOKE, LETTERMAN and WALTER REED

20 Surgery
3 or 4 years of residency
44 residencies — BROOKE, FITZSIMONS, LETTERMAN, WALTER REED, and TRIPLER

21 Thoracic Surgery
2 years of residency
4 residencies — FITZSIMONS and WALTER REED

22 Urology
4 years of residency
10 residencies — BROOKE and WALTER REED

...and Resident Teaching Centers

BROOKE ARMY HOSPITAL, San Antonio, Tex., has 1,700 beds. General and orthopedic surgery are its chief specialties. Its other major interests are general medicine, dermatology, tuberculosis, amputations, neurosurgery, ophthalmologic surgery, plastic surgery, neurology, and neuropsychiatry.
All programs except 1, 7, 8, 15, 17, 18, and 21.

FITZSIMMONS ARMY HOSPITAL, Denver, Colo., has 2,000 beds. Tuberculosis is its chief specialty. Its other major interests are general medicine, general and orthopedic surgery, neurosurgery, thoracic surgery, neurology, and neuropsychiatry.
All programs except 1, 4, 5, 7, 8, 10, 12, 16, 17, 19, and 22.

LETTERMAN ARMY HOSPITAL, San Francisco, Calif., has 1,200 beds. General and orthopedic surgery are its chief specialties. Its other major interests are general medicine, dermatology, amputations, hand surgery, neurosurgery, ophthalmologic surgery, plastic surgery, neurology, and neuropsychiatry.
All programs except 1, 4, 8, 16, 18, 21, and 22.

TRIPLER ARMY HOSPITAL, Honolulu, Oahu, T. H., is a 1,500-bed hospital. It furnishes medical care to patients of the three military Services and their dependents, beneficiaries of the Veterans Administration, and such personnel within the area whose hospitalization is a responsibility of the U. S. Public Health Service.
Programs 6, 9, and 20.

WALTER REED ARMY HOSPITAL, Washington, D. C., has 1,700 beds. Its chief specialties are general and orthopedic surgery, general medicine, neuropsychiatry, neurosurgery, neurology, amputations, audiology, dermatology, ophthalmologic surgery, thoracic surgery, and vascular surgery.
All programs except 16 and 18.

General Information

An applicant for the Regular Army Medical Corps must be a citizen of the United States and a graduate of a medical school, acceptable to The Surgeon General, conferring the degree of doctor of medicine.

Under present regulations, an individual may resign his Regular Army commission either at the end of 3 years' service in the Regular Army, or after completing all obligatory service accrued as a result of participation in this program.

Normally, the doctor with a draft obligation can become board certified 1½ years sooner under the Army Residency Program than can his draft-obligated contemporary who takes a civilian residency.

Time spent in residency training counts towards longevity, promotion, retirement, and the $100 per month additional pay for physicians.

Total pay and allowances of officers with dependents: First Lieutenant $501.44; Captain $576.52; Major $667.72.

If residency training is not offered at a time and place suitable to an applicant, he is under no obligation to accept the Regular Army appointment when tendered.

Equanil*

the anti-anxiety factor

Meprobamate

(2-methyl-2-n-propyl-1,3-propanediol dicarbamate)

Wyeth®

Philadelphia 1, Pa.

*Trademark

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Appropriate to an age of mental and emotional stress,
EQUANIL has demonstrated remarkable properties for promoting
equanimity and release from tension,
without mental clouding.
EQUANIL is a pharmacologically unique anti-anxiety agent
with muscle-relaxing features.
Acting specifically on the central nervous system,
it has a primary place in the
management of patients with anxiety neuroses,
tension states, and associated conditions.[1,2]
In clinical trials, patients respond with ". . . lessening of tension,
reduced irritability and restlessness, more restful sleep,
and generalized muscle relaxation."[2]
It is a valuable adjunct to psychotherapy.
Clinical use is not limited by significant side-effects,
toxic manifestations, or withdrawal phenomena.[1,2]
Supplied: Tablets, 400 mg., bottles of 48.

1. Selling, L.S.: J.A.M.A. 157: 1594 (April 30) 1955. 2. Borrus, J.C.: J.A.M.A. 157: 1596 (April 30) 1955.

officer. In other words there is no difference between the status of a resident and the duty officers in the Army. When housing is available it is furnished as part of an officer's pay. Single residents will have quarters available at all five of the Army teaching hospitals. Housing for married residents is available at four of the teaching hospitals. When housing is not available, a "quarters allowance" is given . . . which amounts to a pay increase.

Basic officers' course

Prior to the beginning of the formal residency training, the Army requires that the new resident, just as any other newly commissioned officer, take a basic indoctrination course. Thus, an individual selected for residency training is first sent to the Medical Field Service School, Fort Sam Houston, Texas, for 22 weeks of training at the Company Officers' Course. This course is offered twice each year beginning 1 January and 1 July. Six months of duty as a Medical Corps officer with a tactical unit in the field is considered the equivalent of attendance at the Company Officers' Course and is a basis for waiving this requirement. Upon completing the course, he is assigned to the hospital where he is to receive his residency training. Commitment for service *subsequent* to receiving residency training is *one year of service for each year of residency training received*, and service of any type prior to residency training does not reduce this obligation.

Residency system

The Army utilizes the modified pyramidal system. There is no automatic exclusion from the residency training to meet a pre-set pyramidal requirement. Except for such events as illness, or other factors beyond the control of the resident, the system is columnar in nature.

Civilian

If vacancies exist, a civilian resident can enter an Army residency program at the second or third year levels. However, he must accept the Regular Army Commission at this time. After acceptance of the Regular Army Commission, the resident is permitted to finish his training but generally for not more than two years. This of course incurs an obligation for *additional* years of Army service.

The Army does not offer civilian residencies except to certain persons who have completed two years of their obligated draft requirements and who have also completed one year of an approved residency. Such a resident may then be subsidized by the Army.

Opportunities are afforded the resident to make research a career, either clinical or non-clinical, under the direction of the Research Development Division of the Office of the Surgeon General, and through the Army Medical Service Graduate

School. The resident may interrupt his residency or, after completing his residency, follow an extensive program of both basic science or clinical research. During normal training, a research problem is required from each resident.

At the present time, it is possible for applicants for residency training to get a firm commitment on the place of training and the date on which training will begin. This commitment, of course, depends upon unforseen variables which may alter conditions in an individual case.

Applications

A doctor may apply for the Army Residency Program regardless of his status in the Doctor Draft. Army resident application forms are obtained by writing directly to:

The Surgeon General,
Department of the Army,
Washington 25, D. C.

Application form for residency training should be forwarded direct to this office where it will be held pending the receipt of the application for appointment in the Army.

Notification

Under present policy, an application for appointment in the Medical Corps of the Regular Army is processed immediately upon receipt, and if an individual is recommended for appointment by The Surgeon General, his application for residency training is processed and the individual is informed as to the outcome of both. This entire procedure can be accomplished within a matter of 45 to 60 days. If the applicant is accepted for Regular Army appointment, and residency training is not offered him in the specialty of his choice, he is under no obligation to accept the appointment when subsequently tendered by The Adjutant General.

Ultrasonic's Publication

The Birtcher Medical Foundation, a non-profit corporation, has recently published the proceedings of the fourth annual conference on ultrasonic therapy of the American Institute of Ultrasonics in Medicine. Residents may obtain a free copy by writing the Foundation at 4371 Valley Boulevard, Los Angeles 32, California.

Clinico–Pathological Conference

Walter Reed Army Hospital, Washington, D. C.

Patient: White married female, 43-year-old.

Past History: Patient did not smoke or drink; had the usual childhood diseases; denied serious adult illnesses; no serious injuries.

History of Present Illness: The patient was in good health until approximately three years prior to present illness, at which time she noted increasing irregularity of menstrual periods and associated cramping suprapubic pain.

In January 1954, an adnexal mass was felt on the left and an exploratory laparotomy was done. A large ovarian mass was found and a total adbominal hysterectomy, bilateral salpingo - oophorectory and appendectomy was performed without any technical difficulty.

The pathological diagnosis of the ovarian tumor was papillary serous cystadenocarcinoma. The malignancy involved both ovaries. Tumor implants were reported on the peritoneal surface. During that hospitalization, the patient's blood pressure was recorded as 126/80.

One month after the operation, the patient was transferred to Walter Reed Army Hospital where her blood pressure was again recorded at 126/80 and her BUN was 10 mgm. percent. At that time vaginal examination revealed thickening of the walls of the vaginal vault. There was a question as to whether this was due to a spread of the malignancy or postoperative fibrosis. However, it was felt that in any case, radiation therapy was indicated. The patient was given 4000 R. total dose of X-ray radiation to the entire abdomen over a period of 91 days, finishing May 1954. Six weeks fol-

lowing the end of her course of X-ray therapy, she had no serious complaints. Her blood pressure was 158/88.

She was next seen as a medical emergency in November 1954, complaining of difficulty in breathing and a heaviness in her chest. Chest X-ray showed increased hilar markings and, on physical examination, there were scattered rales heard in the right apex. The patient was hospitalized.

Physical Examination: A well developed, well nourished white female who was acutely ill. Blood pressure, 210/100; pulse, 120, regular; respirations, 36; moist rales in both lung bases. There was a Grade II apical systolic murmur present and a precordial friction rub. The liver and spleen were not palpable. The lower abdominal wall showed the scar of her previous hysterectomy and there was induration and increased pigmentation over the irradiated areas. No masses were palpated. Pitting edema was noted over the sacrum and the extremities.

Laboratory Data:

Blood: The white blood cell count was 5,400 per cu. mm. with 84 percent neutrophils and 16 percent lymphocytes; hemoglobin was 10.4 grams. Hematocrit 31. Corrected sedimentation rate 35 mm.

Urinalysis: Specific gravity, 1016; albumin, 2 plus; sugar, negative; acetone, 1 plus. Microscopic: 1-2 hyaline casts; 4 fine granular casts; 22-26 white blood cells; 8-11 red blood cells per high power field. BUN, 25 mg.%; CO_2 combining power, 24.4 volumes %; chlorides, 104 meq.; sodium, 125 meq.; potassium, 4.5 meq.; total protein, 5.3 grams %.

Bone Marrow: Showed erythroid hyperplasia.

X-rays: Revealed a slightly enlarged cardiac silhouette. The previous evidence of pulmonary congestion disappeared. Skeletal survey showed no metastases. Barium enema was negative.

Electrocardiograms not revealing.

Course in Hospital: The patient was given a transfusion of whole blood. Following this, she developed acute pulmonary edema with severe shortness of breath, rapid pulse, and blood pressure of 200/110. It was noted at this time that there was spasm of the retinal arterioles with one fresh retinal hemorrhage. Tourniquets were applied to the extremities; and positive pressure oxygen and aminophylline IV were given with improvement. Digitalization was begun. The pericardial friction rub was still heard. Her BUN was 25 mg.%; potassium, 4.5 meq.; sodium, 125 meq.; chlorides, 104 meq. The urine showed a persistent albuminuria with many red blood cells and white blood cells.

One week following hospital admission the patient developed neck rigidity and mental confusion. A lumbar puncture revealed bright red spinal fluid under a pressure of 300 mm. of water. After removal of 7-cc.,

the pressure dropped to 266. Clotting time, prothrombin time and platelet count were all within normal limits. She was started on antibiotics. The patient's hematocrit continued to fall rapidly and she was transfused frequently with packed red cells. Her condition improved and her sensorium cleared. Spinal tap was repeated three weeks later. The initial pressure was 128 mm. The fluid was xanthochromic.

A Regitine test, done because of the severe elevation of the blood pressure, was negative for pheochromocytoma.

The patient had continually increasing edema coupled with albuminuria and an increasing BUN. She also complained of swelling of the breasts and abdominal distention. There was a questionable fluid wave and shifting adbominal dullness. Her appetite was very poor and she had occasional nausea and vomiting. Two days prior to her death, a severe low back pain developed and rather large amounts of narcotics were required for relief. The BUN had risen to 152 on that day and during the evening she had a convulsion with cyanosis and cessation of respirations for approximately 30 seconds. The pulse became weak and irregular. Respirations recommenced after administration of positive pressure oxygen. The blood pressure remained at 180/100. She developed nuchal rigidity and was not responsive. Throughout the next 24 hours, she remained semi-stuporous. She died without regaining consciousness.

Pathological Findings

At autopsy, edema of the lower extremities and an effusion into all serous cavities were present.

There was no sign of tumor anywhere. The other significant observations were as follows:

The heart weighed 430 grams and revealed a left ventricular hypertrophy.

The brain weighed 1,140 grams. There was mild xanthochromia of the meninges associated with the recent subarachnoid hemorrhage.

The kidneys each weighed 150 grams. The capsules stripped with ease revealing a smooth brown surface with numerous fine pin-point hemorrhages. On cut section the surface bulged somewhat. The corticomedullary demarcation was sharp and the cortex had a finely granular surface with hemorrhagic foci. Microscopically, the kidneys showed the changes usually associated with "malignant hypertension," namely: (1) tuft necrosis with or without proliferation of the epithelium of Bowman's capsule or of the tufts; (2) continuity of this necrosis into the afferent arterioles; (3) this arteriolar necrosis consists of replacement of the muscular wall with an eosinophilic granular material which narrows the lumen; (4) hemorrhage and an occasional neutrophil; (5) the interlobular arteries show an intimal proliferation

in fine concentric layers. In addition, there was some increase in the interstitial fibrous tissue.

While the possibility of a spontaneous "malignant hypertension" cannot be excluded, the close correlation of history and physical findings with the cases reported by Kunkler et. al., makes a diagnosis of "radiation nephritis" tenable. Kunkler reports the finding of these vascular changes after 2000-2500 R. to both kidneys. The critical factor appears to be the inclusion of the entire mass of both kidneys in the field. Sparing only a part of one or both kidneys will protect against injury.

This clinical course parallels that claimed to characterize post-irradiation renal damage. There is first a latent period of 6-12 months following abdominal x-radiation. The first complaints are fatigue, dyspnea on exertion, headache and swelling of ankles. Anemia, edema of all grades and hypertension are usually found on examination. Some retinal changes occur and, in the advanced stages, cardiac enlargement with failure is invariably present. The anemia is quite refractory and not due to aplasia of the marrow. Urinary findings consist of albuminuria of varying degree with, occasionally, granular and/or hyaline casts and red blood cells.

Most patients die within a few months of onset of symptoms, death being due to uremia or left ventricular failure. Some recover from the acute phase and are left with signs of chronic renal disease.

Some patients have no symptoms but kidney damage could be found by laboratory examination. These have albuminuria, hypertension and impaired renal function.

Kunkler and his associates conclude that "renal function and exact location of the kidney should be determined before X-ray treatment of the abdomen is undertaken. Unsuspected ectopic and solitary functioning kidneys may be discovered and may demand modification of a standard technique."

Similar renal changes have been reported in animals following radiation.

Reference

1. Kunkler, P. B., Farr, R. F., and Luxton, R. W.: The Limit of Renal Tolerance to X-rays. The British Journal of Radiology. 25: 190-201, April 1952.

2. Furth, J., Upton, A. C., Christenberry, K. W., Benedict, W. H., and Moshman, J.: Some Late Effects in Mice of Ionizing Radiation from an Experimental Nuclear Detonation. Radiology. 63:562-570, October 1954.

This month's Conference was prepared by Major Robert W. Morrissey, U. S. Air Force resident on duty at Walter Reed Army Hospital. Major Morrissey also performed the autopsy.

This month's panel —

MODERATOR: A graduate of a New York State medical school, he took his internship at a large municipal hospital and then served two years in the army. He is currently chief resident in medicine at a voluntary hospital which draws its teaching staff from a number of universities in the New York City area. He plans to enter private practice in 1957.

DR. ANDREWS: A graduate of a western medical school, he served his residency in a large Government hospital in Washington, D. C. His specialty is surgery, and he has been in practice for several years.

DR. KENNEDY: A board certified pediatrician in private practice. His residency, divided between one midwestern and two eastern hospitals, was completed in 1953.

DR. MARTIN: A graduate of a southern medical school, he served his internship at a municipal hospital. An Air Force veteran, his specialty is obstetrics and he is chief resident in a voluntary hospital with university affiliation.

DR. WELCH: After attending medical school in New York City, he served a rotating internship at a university hospital. He has completed two years of military service and is now the chief resident at a new suburban hospital in the northern part of New York State.

Resident Roundtable

Government hospital or voluntary hospital? Which offers the "best" in residency training? Or would it be better to split your residency, spending some time at each?

Resident Roundtable is a transcript of a recorded panel discussion among five residents and specialists, each from a different hospital. This and succeeding Roundtable articles represent the ideas, comment and opinion developed by the panel in response to questions raised by the moderator.

Actual names of those attending the Resident Roundtable are not used. You are invited to contribute to these Roundtables through your Letters to the Editor.

Comparison

MODERATOR: **For purposes of the discussion, government hospital is defined as any non-private, general hospital which receives its financial support and administration from the Federal, state, county, or a city government. Now, what about the government hospital and the voluntary hospital?**

DR. WELCH: You mean as it concerns residency training in quality and quantity?

MODERATOR: **Yes.**

DR. WELCH: Well, I think we would all agree to the fact that there are good and bad points to each.

Although, to be absolutely honest, I think we're bound to get into generalizations which certainly won't apply to *all* government and *all* voluntary hospitals. For example, in a government hospital you're usually going to get mass. You will get lots of work. As a surgeon you will have a chance to do a fair amount of cutting. In medicine you'll see many patients; at times, possibly more than you feel you can adequately supervise.

MODERATOR: **And what do you find in voluntary hospitals?**

DR. KENNEDY: Here you find a mixture. I mean, you'll have private patients and also a certain amount of service cases. But I think the most important thing is you see how your private man handles his case, how he handles emergencies, and how his relationship with the family affects his attitude and treatment.

DR. MARTIN: That's a good point. We have nearly 40 private physicians bringing cases into my hospital. Not one of them has the same routine throughout. I can watch these men, see what they do and learn from them.

But, of course, in some government hospitals you will get some of the advantages which are generally believed to be found only in voluntary hospitals. It's not an exclusive proposition either way.

DR. ANDREWS: Maybe not, but certainly you can itemize the advantages of each type of institution as far as you know. And, also, we have to differentiate between the surgical specialty and the medical specialty residency. Four of five medical residents can get all the benefit, equal benefit from one difficult medical problem. In any surgical specialty, when you get a difficult case, a difficult operative case, the only one getting the maximum benefit from it is the surgeon who does that particular type of case. There must be sufficient cases available for anyone to be trained adequately in a surgical specialty.

In a voluntary hospital it is unfortunate that often there are not sufficient service cases for the surgical resident to get the proper benefit.

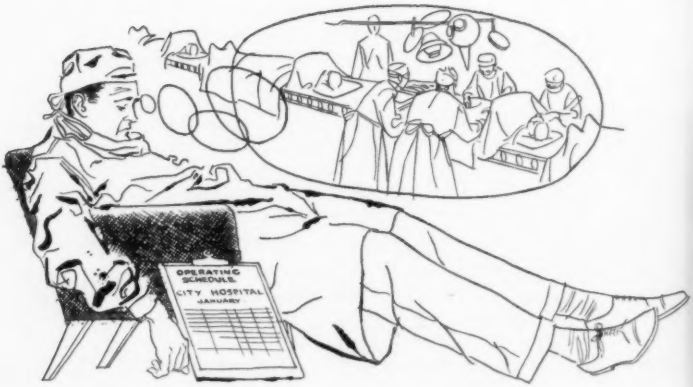
Government advantages

MODERATOR: **How would you list the advantages of the government hospital?**

DR. ANDREWS: Well, I would say that clinical variety is one important advantage. Also the number of cases. This makes for a lot of work, but I think, also a lot of learning. It isn't the volume alone that's important, but with volume, the hospital shares more responsibility with its residents and gives them more authority. To give a resident authority along with good and readily available supervision is, I believe, extremely important.

MODERATOR: **You believe, then, that the responsibility shared by the resident is greater in the government hospital than in the voluntary institution?**

DR. ANDREWS: Very definitely. There are good reasons for this to be a fact. First, service or ward cases generally are not brought in by a private physician who directs the treatment and uses the resident or intern as a scut man. Secondly, the average government hospital ward is generally pretty fully occu-



pied — although there are always temporary slack periods. This more or less allows the resident to accept more responsibility in supervising treatment and making decisions of choice of therapy and management. Naturally, the resident has the chief and the attendings as consultants — and if he gets off the track, they put him right back on again. But, because more responsibility is shared, he is *practicing* medicine or surgery and really training himself for his own practice of the future.

MODERATOR: **Are there disadvantages to the governmental type of hospital in this respect?**

DR. MARTIN: I think that the very fact there is so much work could tend to lower the quality of medical care possible by the overworked staff. But I don't think this can happen if the chief of service and attendings are on the ball. It is only a possibility which suggests itself. I'm not critical of the municipal hospitals. I can't be since I've had no experience. I'm a voluntary hospital trained resident and feel I've had the best training opportunities available.

University connection

MODERATOR: **What do you feel are the advantages of the voluntary hospital?**

DR. KENNEDY: May I set one thing straight? I guess we all feel that the very best training should be that found in any type of hospital having a close university affiliation. I think that professors of clinical subjects who are really devoted to their profession do a helluva lot to keep the entire residency program

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at the right pitch and level. Attendings and visiting men are influenced by university connection and this works in favor of better patient care and in topnotch residency training. So, on this basis, it doesn't matter whether the hospital is government or voluntary, if first we agree that it should be university connected.

MODERATOR: **Do you believe that a hospital should be university connected as a prerequisite for a residency training program?**

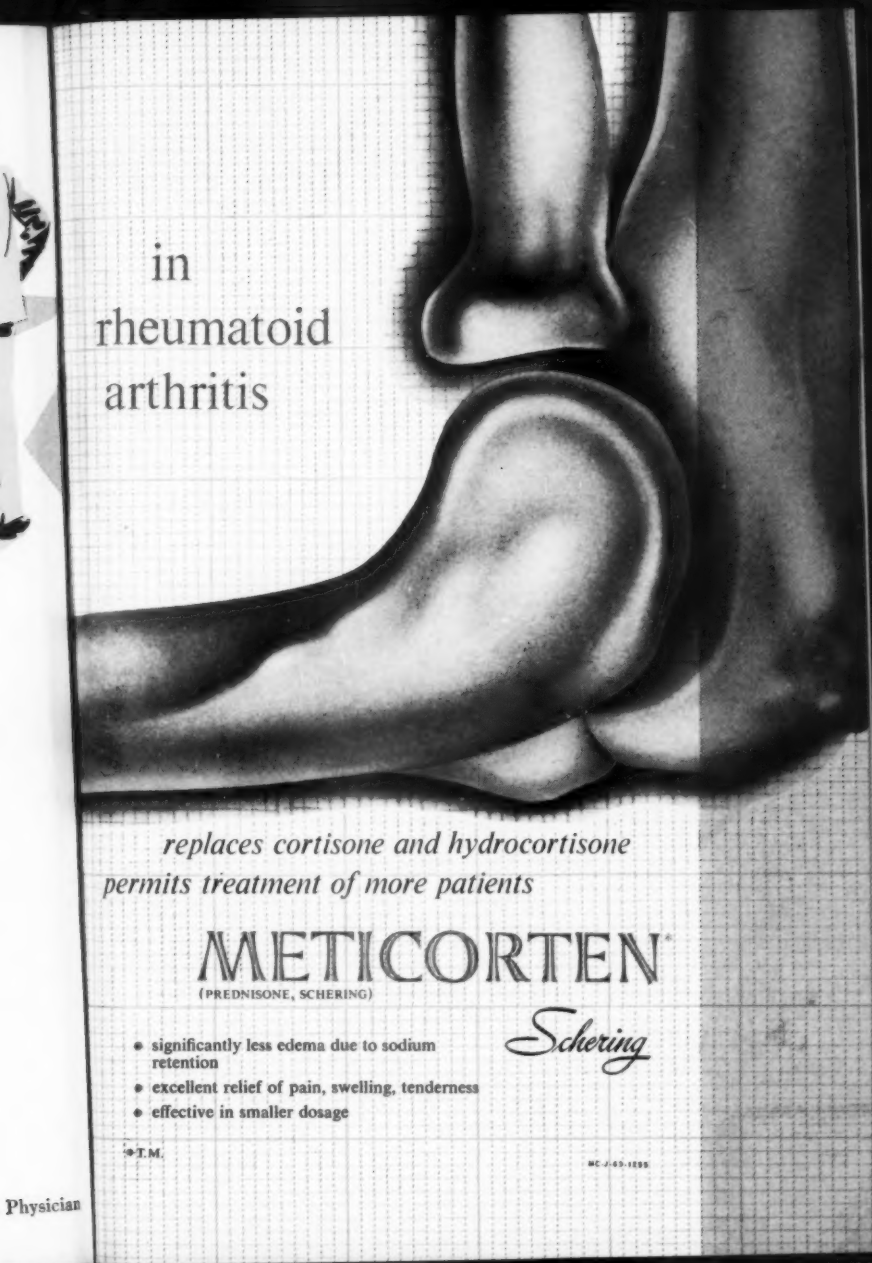
DR. MARTIN: Yes, I do.

DR. PETERS: I agree. I think that is a most important factor. However, there is probably some room for exceptions on a limited scale.

Voluntary hospital

MODERATOR: **Assuming, then, that any comparison we make is between two hospitals both of which are university affiliated, what advantages does the voluntary hospital have?**

DR. MARTIN: In general, I think the real value to be found in the voluntary hospital is that you learn more of the so-called *art* of healing. This has come to be somewhat of a cliche but it does have meaning. The work-up is done carefully and thoroughly. Examination is unhurried and complete, and treatment is not undertaken and managed without regard to the human individual who is to be treated. His feelings and attitudes, as well as his history, are important to the resident. He isn't just a case with an x-ray film number. Also, there are medical bills which he must pay. If a test isn't needed, it isn't ordered.



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Patient Care

MODERATOR: **Nothing has been mentioned about patient care.**

DR. KENNEDY: I don't think you can draw a comparison here. I don't think the quality of care is primarily dependent upon whether a hospital is municipal or private, or government or charity or voluntary.

DR. WELCH: Not dependent, maybe, but influenced.

DR. KENNEDY: I doubt it. The nature, organization and method may be influenced by this but not the *quality* of care.

DR. ANDREWS: I agree. The best residency hospitals are teaching hospitals. Individually they range from bad to good. But I can't imagine that whether they are voluntary or government is an important factor in the quality of medicine practiced.

MODERATOR: **Do you think the physical plant and facilities of the hospital are generally better in the government hospital or in the voluntary?**

DR. KENNEDY: That's a tough question. I split my residency between three hospitals, two of them were private. In my particular case I found the municipal offered the best facilities although the ancillary services were not as good. The newer hospitals seem to start off with the best of equipment. The hospital itself is usually better designed, too. But the older institutions vary a lot. I think this, again, depends on the character and degree of authority exercised by the university. Often the older city, county and state hospitals look like hell from the outside but they are really wonderfully supplied with equipment.

DR. MARTIN: I think the private hospitals have to keep up more, especially if they happen to be a suburban community hospital. Most people in smaller cities are proud of their hospitals and are interested in staying proud of them. However, I will admit that this could mean shiny exteriors with so-so medical facilities.

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MODERATOR: **How about nurses, orderlies and attendants?**

DR. KENNEDY: With the important exception of the older nurses, many of whom are devoted to their positions, there is a lot of shuffling around among nursing personnel. Salary is part of the reason.

DR. WELCH: I would say the nurses, orderlies, and attendants vary tremendously in quality from one hospital to another.

DR. MARTIN: At some of the so-called best hospitals you have interns and residents acting as orderlies and attendants. The quality is excellent.

DR. ANDREWS: I know you're kidding, but just the same there is some truth in what you say. I think the resident in that situation is the one to blame. He is a poor administrator if he has to do the nurses' work.

Split residency

MODERATOR: **You mentioned a split-residency before. Do you think there is an advantage in this?**

DR. KENNEDY: Very definitely. It is true that in surgery, you often find yourself at the feet of a great man, learning his technique by watching and assisting him. And, when you have the opportunity to train with a master who is way above his colleagues in both judgment and technique, you're in a damn good spot —a really enviable position. You'd be crazy to leave voluntarily.

But, how many great masters are there? How much room is there around their feet? It is the rare surgical resident thus blessed. I think other surgical residents and all medical residents would benefit by seeing at least two sides of hospital medicine, the municipal or charity side—and the private side.

DR. ANDREWS: I strongly disagree with this idea. I stayed on with one surgical program in a Government hospital and I don't feel that my training has been anything but tops—at least I was exposed to the best. Whether or not I was able to absorb it or not

is a different matter which bears on my ability, not on the hospital's program. I admit, I thought I'd like a little private patient work, but I had plenty of work to do. That, to me, was important—most important. My chief was, perhaps, no Master with the capital M, but I think he was a terrific performer to watch, assist, and learn under.

MODERATOR: **Assuming you split your residency, how would you divide up the years?**

DR. MARTIN: Let's keep in mind that it is possible to get both types of hospitals in one program; you may stay in one residency program and be rotated through both government and voluntary hospitals. For example, a voluntary hospital which is affiliated with a VA institution through a common faculty group. However, I think the last two or three years are best spent in a large municipal hospital, the middle year or years in a private hospital, and the first year in a municipal hospital to get you moving quickly in a general background of your specialty. The sum total would be to take a little bit from that man's technique and a little bit from the other man's technique and also learn a little bit about the practical aspects of medical practice, how to speak to relatives, how to handle patients, to learn different types of bedside manners and choose between them the one that fits your own personality.

In this last year spent at a municipal hospital, the resident would be a trained surgeon, competent to handle any of the surgical emergencies that can occur. He would have a tremendous amount of responsibility, which I think helps train men for private practice.

DR. KENNEDY: In the ideal situation, I think the order should be the opposite of what Dr. Martin said. I think perhaps the first year or two years of a residency should be in a municipal or university teaching hospital, for there is nobody smarter than an intern or a fourth year student and you are still close enough to know it all and you are still used to didactic training. In your first two years you are very susceptible

and your professors will speak to you in an informal manner. I think your third and fourth and last year of residency should be in a private hospital.

Hospital affiliation

MODERATOR: **Dr. Andrews?**

DR. ANDREWS: I think it's important, before going into private practice, to have hospital affiliation. I think the best way to do it is to be chief resident in a private hospital in the community in which you want to settle. Having chosen your specialty and having gone as far as three or four years, you should by then have made up your mind where you would like to settle. And then I think you should approach the best hospital in that immediate area.

Many places will give you a staff appointment after you have been chief resident in the hospital, and it is certainly easier to go out into practice assured of a staff appointment. It is also a matter of the order of residency in which I differ with Dr. Kennedy.

DR. WELCH: One moment, please.

MODERATOR: **Yes, Dr. Welch?**

DR. WELCH: We are going into this business of taking a few years at this hospital and taking a couple of years at that hospital and applying for a residency here and applying for a residency there. My training was broken up. I served my internship. I had one year of residency training. I wanted to get out, I had another appointment, was called up to the services, I spent two years in service. I came out, spent two more years in residency to complete my three years of training. Now, this blandness with which people say, "take one year here and then apply for a residency." They are not that easy to get, not really approved ones. Senior residencies are the plums. They are the final thing that you're going to get, a culmination of the three or four years you have been working. You take any so-called top notch teaching residency and you find that if you want a senior residency there are only two ways you are going to

get it. One, you are going to start at the bottom and sweat and work your way up to that third or fourth year or fifth, whichever it may be, and two if you are just getting out of service with two or three years of residency behind you and the senior resident is just about being drafted with no other fellow lower down the line to take his place or, well, you just have plain blind luck of stepping into a senior residency. But skipping from hospital to hospital will not decide what you are going to do.

DR. ANDREWS: That's very true in surgical specialties.

MODERATOR: **We'll have to stop here for now.**

I guess I sleep tonight—When she's on they don't make a peep!

Equipping the Ob-Gyn Office

What equipment is needed in the beginning practice of obstetrics and gynecology? *Resident Physician* recently put this question to a number of practicing ob-gyn men. Based on their answers, this article is presented as a guide to those residents who will soon be setting up a practice in the specialty. Since cost is an important factor in the selection of equipment, an approximate range of prices has been indicated for each item wherever possible as an aid to the resident in estimating his overall equipment investment.

An office for the practice of obstetrics and gynecology is unique in at least three respects:

1. The practice deals exclusively with women.
2. The woman patient returns to the office at regular intervals.
3. The ob. patient often becomes clumsy as the pregnancy progresses.

Women only

All three factors mentioned indicate that the waiting room is of great importance. First, it should have feminine appeal—not as a boudoir, but like a living room in the home.

Everything about the waiting room should be subtle, relaxing, and in a quiet harmony of color and design. From the pictures on the wall to the placement of the lamps and the lighting arrangement, the waiting room should invite the patient to enjoy the comfort of the surroundings.

Although most men appreciate "pretty things," women insist upon them. Also, a man might sit on an uncushioned chair in a barbershop for 20 to 30 minutes without complaint. A woman, especially a pregnant woman, wouldn't put up with this. Straightback chairs? Yes. But *not* hard bottom chairs.

Selection of furnishings should be made with ease of maintenance and cleaning in mind. A woman has sharp eyes and a quick tongue. Dirty ashtrays, dog-eared magazines, soiled chairs or drapes, even dust; all are subject to her critical meas-

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[1] Howell, T.H.; Harth, J.A.P., and Dietrich, M.: Practitioner *173*:172.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

ure. Her "clinical impression" may make her first visit her last.

Waiting room

In previous articles, mention was made of plastic and leather-covered furniture. According to our survey, the majority of obstetricians prefer plastic-covered chairs. Although a number chose overstuffed furniture, many thought pregnant women were uncomfortable in the very soft, deep chairs. The cost of an attractive plastic chair is $25 to $35 and the minimum number required is six. (The husband may come on the first visit, but after that he is happy to wait in the car.) Overstuffed chairs are more expensive, prices ranging from $50 up.

Carpeting in the waiting room was preferred by most respondents, their cost varying from $7 to $12 a yard, installed.

Table lamps and floor lamps were chosen in preference to wall lights. Since patients sometimes wait long periods in an obstetrician's office, the lamps should be chosen not only for their attractiveness, but for the amount of illumination they give. The cost of a good lamp is at least $25.

Tables are needed for ashtrays and magazines and can be bought for $25. Incidentally, get large ash trays, preferably those that can be emptied easily.

A few obstetricians took into consideration that many of their patients have small children who accompany them to the office and so have a few small chairs and books available for the tots. Cost: from $5 to $15 a chair.

Consultation room

The consultation room for the obstetrician poses no special problems except that it should be as completely soundproof as can be afforded. Rugs, drapes, and special ceilings assist in this purpose. The decor of the room should be dignified, but not severe. It should tend to invite conversation. For the cost of the desk our informants quoted prices of $75 to $300, depending on size and type.

Chairs varied from $75 to $150 for the physician's chair and $25 to $50 for the patient's chair. Some obstetricians have no third chair. Said one, "If I let the husband stand during our conversation, he generally has few questions, leaves quickly. But if he sits down he settles back, asks for a complete lecture on obstetrics."

Examining room

While many busy obstetricians have two or more examining rooms, a single unit is considered adequate for the beginning practice.

A table of course is required. Two main points to be considered are its strength and ease of manipulation. A new table can cost as little as $125 or as much as $700 to $800. The average price quoted in our survey was $300. Stirrups should be

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attached and should be simple in operation. Some tables come equipped with electrical outlets and basins. These are valuable features according to our survey group.

A small, sturdy stool for mounting the table should be available. It should cost no more than $15 to $20, but make sure it's as slip-proof as possible.

A head light is required. The shadowless model with a wide base was preferred by the majority of responding obstetricians. Some indicated a preference for one that attaches to the wall.

A treatment stand and cabinet are necessary to hold the many instruments and speculums needed. Both may be purchased for under $200.

Dressing room and lavatory

Since these rooms are used so frequently, special care should be taken in furnishing them. The dressing room should be separated from the lavatory and adjacent to the examining room. It should be well-lighted, have a seat and a mirror. Hangers and hooks should be supplied for clothing and gowns. The door should be able to be locked from within. The total cost of dressing room equipment is usually less than $75.

The lavatory, aside from being readily available to both the waiting room and the examining room, should contain a wash bowl, stool, a mirror, shelf, waste basket, soap and towels. Your nurse will have access

to sanitary items and will make this known to each patient.

Instruments

Either a sterilizer or an autoclave or both will be needed. A new sterilizer costs about $35 to $60. Autoclaves run from $220 to $550. Respondents were divided in their preference.

Special instruments are required by the obstetrician. An electric cautery is important and the cost of one suitable for the ob-gyn man can cost up to $350. An apparatus for tubal insufflation is required at a cost of about $150. A blood-pressure device, preferably one that can be mounted on or near the examining table, will probably cost in the neighborhood of $40.

Other instruments such as forceps, speculum, ring sets, etc., can usually be purchased for under $150 for the lot. This sum includes the drugs that the obstetrician needs handy. A scale can be purchased for under $50.

Laboratory

A microscope, if not already available, is necessary — cost will be about $250 to $300 new and $175 second hand. Other lab equipment for the simple CBC, sedimentation rate and urines will cost about $100. More extensive lab facilities aren't needed by the beginning obstetrician, according to the panel.

X-ray and fluoroscope were not purchased by any of our informants. Most indicated a view-box was needed. Cost: $25 (standing) to $50 (wall).

In summary, the total cost of office equipment of those responding to the RESIDENT PHYSICIAN survey was as little as $2000 to a bit over $4000.

There are two ways in which a resident can get a head start: 1) consult an office equipment company which maintains an advisory staff having experience in equipping doctor's offices, and 2) make a tentative list of equipment items you think you'll need immediately —together with cost estimates.

Reprints of this and previous articles in the series (Internist's Office, and Pediatrician's Office) now available from the publisher at 30 cents (in coin or stamps) for each copy.

Next month: Equipping the Ophthalmology Office

Life Insurance: How Much?

Three basic questions face every insurance buyer: "How much shall I spend on life insurance? What types shall I buy? How shall I have the money administered after my death?"

Philip L. Azoy

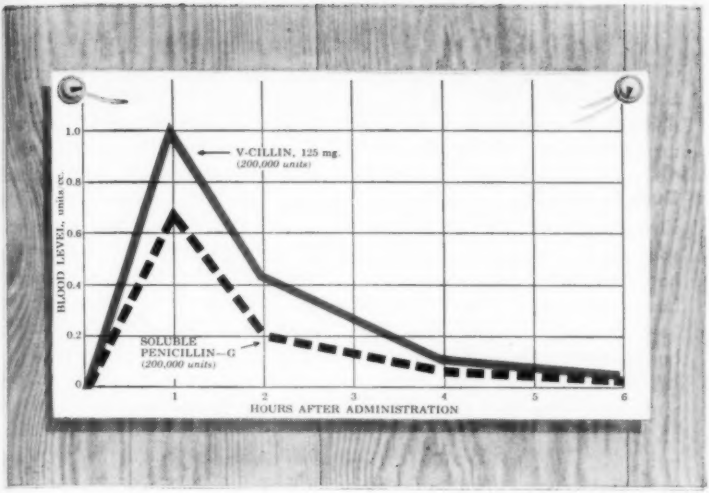
Despite their abilities, insurance men cannot calculate exactly how much insurance you should carry. Naturally, they want you to have as much protection as possible. But, as with most everything in life, there is a saturation point. And you alone must decide how much you can afford to spend on life insurance without seriously depriving yourself and your family of income needed for everyday life.

But whatever you do, *don't put off getting insurance.*

Any insurance salesman can give you some sad case histories involving individuals who finally decided to get insured, but died or were killed just before they got around to signing up.

You know you're not going to be here forever—so face the fact now. The only thing you don't know is *when* your leaving. And by putting off your insurance program, you are gambling with the security of those who trust and depend on you for support.

ABOUT THE AUTHOR—Graduated from Princeton University, Philip Azoy served four years with U. S. Army Intelligence during World War II. After three years as an insurance broker, Mr. Azoy accepted his present position as special representative with the Trust Department of a New York City bank.



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So far, doctors are not covered by Social Security. This makes the problem of insurance even more urgent for you.

Budget

First thing to do is to sit down with your wife (if you're not married and have no dependents, you have no insurance problem) and figure out how much you can pull out of your budget for insurance.

The amounts you must spend on rent, food, clothing, entertainment and incidentals can be pretty well estimated. Remember that your wife, in case you die within the next year or so, may have young children to raise. She probably won't be able to find a job that will pay enough to provide for a nurse for the children while she works. So it is your responsibility now to make sure your family would have enough income to live on during the crucial years while the children are young. Security, after all, is the basic aim of a life insurance program.

Get information

Second, get some facts and figures. You may run into difficulty here because a great many insurance companies leave it solely to their agents to present the figures during a person-to-person chat.

Some, however, do mail out descriptive information (see RP, *September*, 1955). Ask for features (convertible? renewable?) and prices of their *term* policies per thousand dollars of coverage. If you'd rather wait until you have a good deal of information before seeing an agent, plainly and definitely indicate this fact on each postcard you mail or you might end up in the middle of an agent's conference held for your benefit. Obviously, this wouldn't be fair to the agents since you can't buy insurance from all of them. And their time, like yours, is valuable.

With data before you in black and white, you can compare features, costs, and arrive at a fair idea of what and how much you want and what you might expect to pay for it.

Compare plans

Armed with this information you can telephone several agents of com-

panies in which you have confidence. Tell them frankly you are making comparisons between companies. Rather than waste time (theirs and yours) you'd like them to make some simple suggestions for your needs — together with the annual estimated net cost to you. Be definite about wanting nothing elaborate, simply a pencilled memo with the agent's name.

If they agree to do this, then tell them the amount you are able to allot each year for insurance for as

Plan A

Let's assume that you and your wife can budget about $150 a year for life insurance. This may seem to be a mighty big assumption. But, remember, at this stage of the game, *any* amount of money you spend for insurance will involve plenty of sacrifice on your part. Your question: Is the sacrifice worth the object?

TYPE AND PRINCIPAL AMOUNT OF POLICY	APPROXIMATE ANNUAL PREMIUM
1. A $10,000 SAMA insurance policy	$50
2. A GI policy at $10,000 (5-year, renewable term issued after April, 1951)	$40 (if you are 30 years old)
3. If you have both (1 & 2), your remaining allowance might be applied to an $8,000 term policy having a convertible feature	$60
4. If you have 1 *or* 2 above—or neither, your insurance money can be put into term insurance up to $20,000	$150

Summary

In the event of your death your family would have $20,000 to $30,000 face value in life insurance money coming to them. Your wife could use a part of this to clean up any outstanding bills and part to get herself going again on a career or in a job; the remainder could be invested to provide a small income. If you live, this term insurance has no cash savings or loan value to you. Actually, this plan is a *temporary* measure to give your family maximum protection in case of your death. Probably, you will take on "living insurance" later on when you can afford it. That is, you will change over some of your insurance coverage to include *permanent* life insurance policies at a greater premium cost per thousand but with a savings and a loan feature which will give you a return even if you live out the entire length of the policy period.

far ahead as you can estimate, perhaps up to five years hence. Don't be brave at this point. Whatever you do, don't give the agent the idea that you can afford one dollar more than you actually can. After all, the plan he'd draw up for Rockefeller would hardly compare with the one he might draw up for a $50 a month intern or $75 a month resident. So give him the true situation and he'll be able to give you a realistic estimate.

Also, be sure to mention your present family situation. If you have other assets, easily convertible to cash in event of your death, tell him of this, too. And as a final note, you can give him the nature and extent of your present insurance policies—*without* sending him the policies themselves.

Now, with a number of these "memos" plus the other descriptive booklets you've previously acquired, you should be in a good position to make an intelligent and informed choice.

No matter what you decide, you have incurred one important moral obligation. Address a note of thanks to all agents taking their time to help you. Let them know of your final decision. This is a courtesy which is too often forgotten.

Example

Let's take an example which may or may not parallel your situation. Assume you have the $10,000 term policy offered by the Student Amer-

ican Medical Association. If you're an ex-GI, a smart one, you still have your National Service Life Insurance (GI policy) up to $10,000 worth. You probably have it on a term basis.

This would give you a total of about $20,000 in term coverage. If you're about 30 years old and married, this is a fair minimum coverage, according to most insurance experts.

Adequate protection

But, if you are infanticipating—or already have one or two babies, most insurance men will tell you you're under-insured and taking a grave risk with the future of your family. And they're probably right.

Suggestion: Get yourself an addi-

Her most important asset is her *health*. ➤ With health, she is happy, relaxed and capable of serving her family and community. ➤ Today, parents turn to their family physician for advice on scientific methods of child-spacing, for it is he who recognizes the medical necessity for such advice . . . guides her . . . and earns her gratitude. Without this attention from her doctor, in whom she places her confidence, her family goals would not be easily obtained. It's the incomparable knowledge, skill and experience of her doctor...and doctors everywhere...whose judgment is to recommend for their patients' health and happiness — *Koromex*

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tional $10,000 to $20,000 in term insurance. This will cost from $80 to $220 a year depending on where you get it and the amount you buy. Make certain your term policy offers you the right to convert to a *permanent* form of insurance (such as 20-payment life) without a medical exam.

This will provide you with from $30,000 to $40,000 in insurance—not an excessive amount for your family position, but one you should be able to carry without too much sacrifice. And more important, in the event of your sudden departure from this life, your wife with two young children to support, will be able to get by pretty well for a number of years—perhaps until the children are through high school.

Changes are necessary

Naturally, as you leave your residency and begin to establish your practice, you will also make changes in your insurance program. It will get larger and you will convert some of your term policies to whole life policies. But right now, you

---

Plan B

If you are able to allot $300 annually to insurance:

TYPE AND PRINCIPAL AMOUNT OF POLICY	APPROXIMATE ANNUAL PREMIUM
1. A SAMA policy of $10,000	$50
2. Your GI term policy of $10,000	$40
3. Another term policy of $20-$30,000 with a convertible feature	$160-$240
4. If you have neither 1 or 2 above, increase the difference.	

Summary:

In the event of your death, your wife would have $40-$50,000 in term insurance principal which, if invested at 5% would give her an income of $170 to $210 a month. (The principal would not be touched at this rate—but a plan could be arranged whereby she would dip into the principal for an *additional* $50-$100 a month and use up the principal in a specific number of years.)

After you enter practice and begin building your income, you will periodically review your insurance program with an eye to converting and replacing part of your term insurance with the permanent types of insurance such as whole life, or family-income plans. However, hold on to your GI policy no matter what—you just can't get insurance any cheaper than this.

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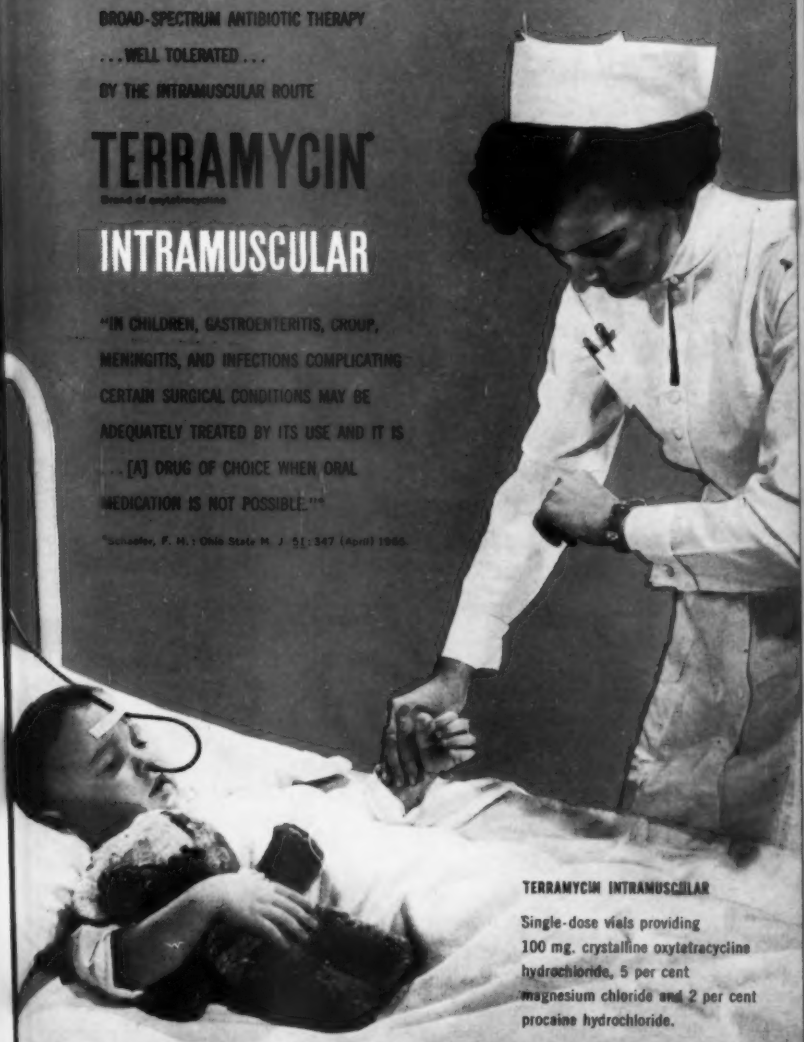
*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.



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can't afford too much money for insurance, and with your insurance mostly in term policies you'll get near-maximum coverage for the least amount of money spent.

Remember, four years after your internship you must convert your SAMA policy to another form of insurance. You'll probably investigate family income type policies, too, as you build up your practice.

Now that you've started on an insurance plan and figured out the yearly cost for the types of insurance you will buy, there is one final question awaiting decision. It is: What provisions shall I make now for the administration of the insurance cash my family will receive when I die?

Provide for administration

Insurance companies will keep your money, invest it, and send your wife a monthly check. For example, they might be willing to guarantee your wife $120 monthly for life without touching the principal (in this case, $40,000) or about a 3½% return. If she wanted a higher income during the period the children are growing up, she could arrange for that with consequent reduction in the principal.

Flexible agreement

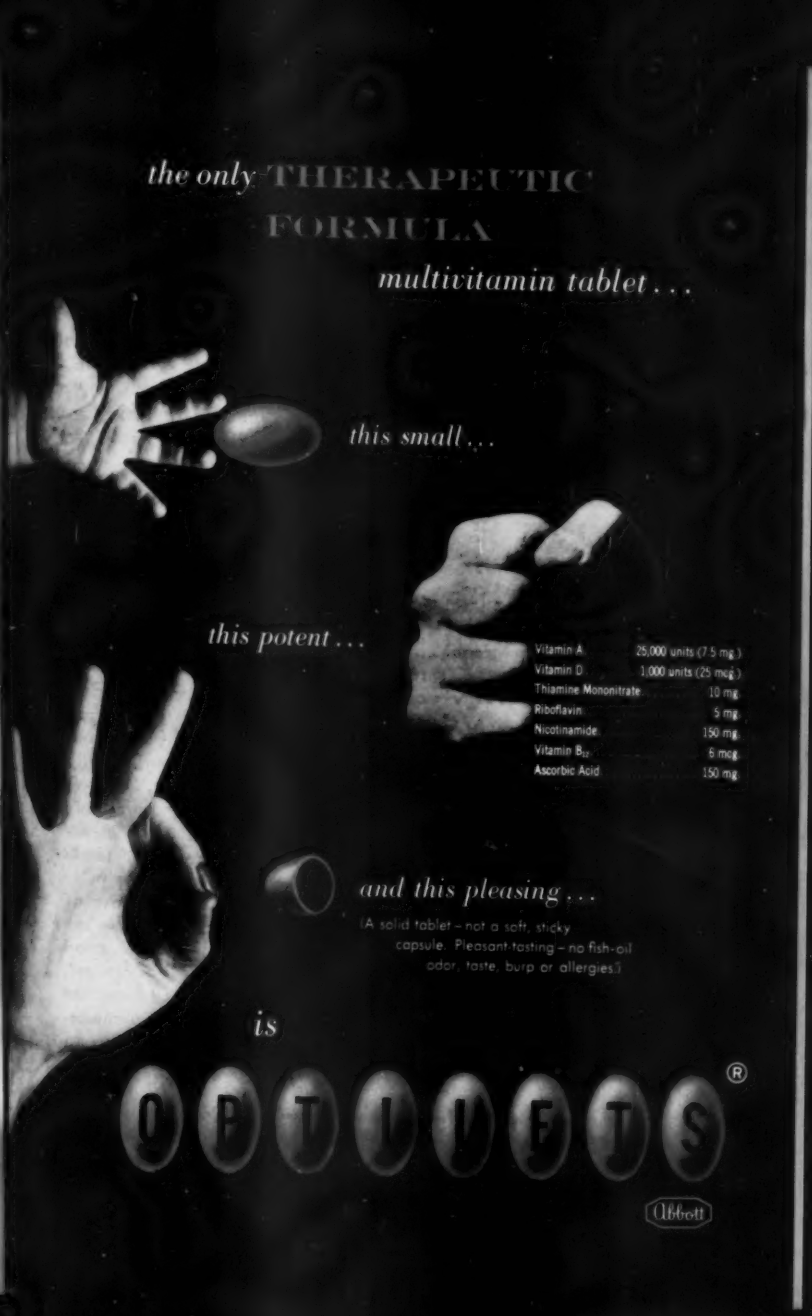
In arranging your insurance benefits to take care of your family's unknown future financial needs, most insurance companies now permit a flexible beneficiary agreement. This simply means that your insurance proceeds will be left with the insurance company, accumulating interest, until your wife elects a method of payment. She may take her time in deciding, or, if she knows her needs, she can withdraw all or part of the principal immediately. She could also elect to have a monthly income for life, or for a specific period, or any combination of these she chooses. In this way, you won't be binding your wife to a method of payment which, in the light of future events, may work a real hardship on her and the children.

One other important advantage of this type of agreement is that it qualifies the insurance estate for the marital deduction for estate tax purposes. This may not seem to be important to you now, but remember, you are planning now for the future.

Common trust funds

However, there are several other alternatives. You can direct that the face amounts of the policies be paid to your local bank, whose trust department will administer the money. You can ask the bank to invest this money in sound stocks, preferred and common.

Remember, most educational and charitable institutions and pension funds invest a large part of their assets in stocks because of the higher rate of return. Also, there is the important fact that stock prices and dividends tend to keep pace with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inflation. Moreover, these days many banks have what they call a "common trust fund." They invest the proceeds of many small estates like yours in sound stocks, then pay out the dividends as income to your beneficiary (minus a small service charge). Currently the rate of return is about 4½%, or substantially more than the insurance companies pay.

A good man to know

Now if your wife is a very capable and money-wise woman, she may prefer to manage the money herself with the help of an investment adviser. This man might be a local broker or perhaps your banker. Here again, it is strictly up to you. But one of the wisest moves you could make would be to contact your local banker for advice on such a question. It's good to remember that sometime in your life you may need to borrow money from the bank to finance new medical equipment, a new car, or the mortgage on a house. Thus, your banker is always a good man to know.

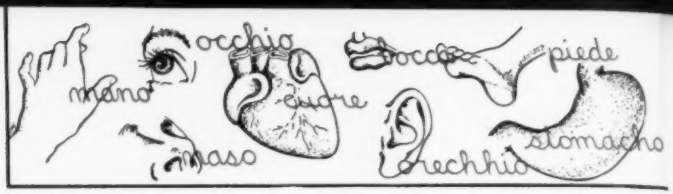
Compare . . . But Don't Delay

Sound purchases of insurance, like anything else, usually begin with a comparison. That's why we suggest you do it. Not just the price alone, but the features involved, too.

However, there's always one danger. Human nature being what it is, we all hesitate to choose between six or seven good alternatives. Too often, no decision is made, the purchase is postponed. But remember, postponing your insurance decision could easily be the worst mistake you could make—and the costliest. So keep this in mind: reputable insurance companies stay reputable through customer satisfaction. And the vast majority of life insurance companies are reputable. You'll find that competition tends to keep these companies together in what they are able to offer you. And though you'll find some differences in the costs of similar policies, these differences shouldn't worry you to the extent that you put off getting insurance. Pick one that looks good to you. Call the agent while the subject is fresh in your mind.

Or, if you just can't make a choice, get in touch with an insurance counselor, one who is known to you by recommendation of a friend or relative. He'll sit down with you and set up an overall program for your insurance needs. The important thing is, he'll do it *now*.

As a reminder, double indemnity provision (doubles the principal if you die from an accident) and waiver of premium (in case of permanent disability—as defined in each company's policy) is recommended. The added cost is small.



The Doctor Speaks Italian

The problem of language barriers is common, especially in large hospitals or in medical centers located in areas populated by one or more foreign born groups.

Because the average resident cannot devote the time required to master many foreign languages, RESIDENT PHYSICIAN presents this third in a series of brief guides to foreign phrases in the more common languages spoken in the United States.

The completed series of language guides, including French, Spanish, Italian, German, Polish, and Yiddish, will be bound and reprinted as a booklet available at cost.

Keep your "language finder" open in front of the patient and don't worry too much about the pronunciation of words. Your patient will be eager to help.

For examination of Italian-speaking patients.

Basic rules of pronunciation

1. The sound of vowels is constant with the exception of e which has two sound values.
   a—*ah*
   e—*eh*
   e—*ay* (generally used in word endings)
   i—*ee*
   o—*oh*
   u—*oo*
2. The sound of consonants varies depending upon the consonant vowel combination.
   C before a, o and u, is pronounced as the C in *cat*.
   C before e and i takes the sound of CH in *chair*.
   G follows the above rules also: before a, o and u, G is "hard" pronounced like G in *go*: before e and i, G becomes G as in *gentle*.

However, both C and G are pronounced "hard" before e and i when the letter H appears between the consonant and vowel. Thus, CH (before i) in occHIo is pronounced *kee* and Pinocchio becomes *pee-noh-kee-oh*.
GU as always pronounced *goo* as in *goose*.
GL is pronounced like the *li* in *polio*.
GN is pronounced the same as the *ni* in *onion* and *senior*.
SC and SCH have the ess sound coupled with C and CH and the pronunciation follows the rules for C and CH (see above). One variation; SC before e or i becomes *sh* as in *sheep*.
R is trilled at tip of tongue rather than gutteral roll.
Z is like *tz* in *tzar*.
QU is pronounced as it is in English.

3. Italian words, generally, are pronounced with the accent on the second last syllable. In words of only two syllables, the first syllable is usually emphasized.
4. Plurals do not end in s as in English, French and Spanish. Masculine gender plural nouns usually end in i, while feminine plural nouns generally end with e.

Anatomical terms

head—testa or capo	neck—collo
eye(s)—occhio (occhi)	Chest—petto *or* torace
ear(s)—orecchio (orrecchi)	breast—seno
nose—naso	heart—cuore
mouth—bocca	lungs—polmoni
teeth—denti	shoulders—spalle
tongue—lingua	back—schiena
throat—gola	arm(s)—braccio (braccia)
finger—dito	hands—mani
leg(s)—gamba (gambe)	rectum—retto
feet—piedi	buttock—natica
stomach—stomaco	womb—utero *or* matrice
bladder—vescica	

Courtesy phrases

Note: Normal courtesy requires the frequent use of the titles *Signore* (Sir), *Signora* (Madam) and *Signorina* (Miss). For the sake of brevity these titles are used only in the first three phrases below.

Good morning, Sir	Buon giorno, signore *boo ohn jeeohrnoh seenyohray*
Good afternoon, Madam	Buona sera, signora *boo ohna sayrah seenyohrah*
Good night, Miss	Buona notte, signorina *boo ohna nohtay, seenyohreenah*
Please	Favorisca

(In giving directions to patients, *favorisca* should be used to begin each statement.)

Please sit down	Favorisca s'acomodi
How are you?	Come sta lei
Very well, thanks	Benissimo, grazie
Do you understand	Comprendi, (capische)
I (do not) understand	(non) capisco
Excuse me	Scusi
Pardon me	Perdoni
Very good	Buonissimo
Today	Oggi
Tomorrow	Domani
Yesterday	Ieri

General questions

do you feel sick	vi sentite male
do you have pain	vi fa male
—much pain	—molto male
—mild pain	—male leggermente
where	dove
here	qui
when	quando
how many years	da quanti anni
how many days	da quanti giorni
how many hours	da quante ore
how many times	quante volte
how old are you	quanti anni avete
where were you born	dove siete nato

Directions to patients

do as I do	fate come faccio io
relax	calmaveti
relax more	calmaveti di piu
open your mouth	aprite la bocca
open your eyes	aprite gli occi
breathe deeply	respirate profondamente
breathe through your mouth	respirate per la bocca
hold your breath	trattenete il respiro
push	spingete
cough	tossite
please don't move	favorisca non s'incomidi

Diseases

measles	morbillo
scarlet fever	febbre scarlatta
chicken pox	varicella
small pox	vaiuolo
pneumonia	polmonite
typhoid fever	febbre tifoidea
enteritis	enterite
U.R.I.	freddura, (coriza)

Systemic inquiry

Head	
trauma	trauma
unconscious	incosciente
did you faint	siete svenuto
are you dizzy	vi sentite il capogiro
headache	mal di capo
Eyes	
sight	vista
clear vision	buona vista
near	vicino
far	lontano
Ears	
he is deaf	egli e sordo
noise in the ears	rumore alle orecchie
Nose	
coryza (head cold)	coriza (raffredoro di testa)
did you have a nosebleed	vi e sanguinato il naso
Throat	
do have frequent sore-throat	vi sentite il mal di gola spesso
Cardio-respiratory	
do you tire easily	vi stancate facilmente
are you short of breath	vi sentite mancare il respiro
does your heart beat fast	vi batte il cuore presto
do your feet swell	vi gonfiano i piedi
do you have pain in the chest	avete dolori al petto
—sharp pain	—dolore acuto
—dull pain	—dolore vago
—when you breathe	—quando respirate
do you cough	tossite
do you spit	sputate
sputum	sputo
bloody sputum	sputo insanguinato

have you lost weight	siete diminuito di peso
pound	libbra
does someone in your family	C'e qualcuno nella vostra
have a cough	famiglia che tossisce

Gastro-intestinal

do you have a good appetite	avete un buon appetito
do you have a poor appetite	avete poco appetito
are you nauseated	vi sentite nauseato
were you nauseated	vi sentivate nauseato
do you vomit	vomitate
do you have diarrhea	soffrite di diarrea
are you constipated	siete stitico
feces	feci
black	nero
white	bianco
yellow	giallo
brown	bruno
bloody	insanguinato
do you have cramps	avete dei crampi
after meals	dopo i mangiade
before meals	prima dei mangiade
did you take a laxative	avete preso un lass-ativo
did you take castor-oil	avete preso dell'olio di ricino

Genito-urinary

urine	urina
do you get up at night to urinate	vi alzate la notte per urinate
does it burn	vi sentite bruciore
chills	brividi de freddo
fever	febbre

Obstetrics and gynecology

at what age did you begin to menstruate	a quale eta vi sono incominciate le menstruazioni
how many days do you flow	per quanti giorni avete il flusso
1 to 10	una, due, tre, quattro, cinque, sei, sette, otto, nove, dieci
do you have discharge	scarciate (avete dello scarcio)
when was your last menstrual period	quando avete avuto l'ultimo periodo menstruale
are you pregnant	siete incinta
do you have pain with your period	i vostri periodi sono accompagnati da dolori

how many times have you been pregnant	quante volte sieta stata incinta
how many children have you had	quanti figli avete avuto
how much did the largest weigh at birth	quanto pesava il piu grande dei vostri bambini al momento della nascita
what was the duration of labor	quanto sono durate le doglie del parto (quanto dura)
Pediatrics	
did you have trouble with the child's delivery	si sono stati die disturbi durante il parto
how are the child's stools	como sono gli escremente del bambino*
constipated	stitico**
diarrhea	diarrea
how many in one day	quante volte in un giorno
does the child eat well	il bambino mangia bene
any vomiting	c'e del vomito
does the face turn blue	il bambino* diventa nero
does the child seem tired	il bambino* sembra stanco
does it hurt	fa male
it won't hurt	non fare male
it will be finished in a minute	in un minuto sara tutto finito
do you want a piece of candy	vuoi una caramella
did you take the temperature	avete misurato la temperatura
what was the temperature	che temperatura avete
what a big, handsome boy	che bel ragazzo
what a beautiful little girl	che bella ragazzina
baby	bambino*
good	buono

* bambina if it is feminine

** stitica if it is feminine

Languagitis

CALLED ONE NIGHT to attend a Mexican woman, I felt relieved to find she had a friend with her who spoke a smattering of English. But my question as to what bothered the patient brought the response, "Thees lady, her mattress is upside down."

I carefully inspected the bed, mattress, and coverings and found nothing unusual.

Suddenly, a thought hit me. I dug down in my bag for a small Spanish to English dictionary and after the word "Matriz" I found—"*uterus or womb.*"

With no further attempts at bed-making, I replaced the patient's acutely retroflexed uterus.

What's the Doctor's Name?

James Gallagher

Born at Winchester, New Hampshire, October 9, 1860, died, August 7, 1927.

Entered Harvard Medical School in 1880.

Interned at Boston City Hospital in 1884. (When he left Boston City, the superintendent said: "There goes a young man who will never come to any good.")

* *

Served as surgeon with the U. S. Army in Apache uprisings.

In 1895, President and Mrs. McKinley became his patients.

* *

Was a Colonel with Teddy Roosevelt's "Rough Riders" which he helped organize.

He commanded cavalry brigade at San Juan Hill; later became military Governor of Cuba (1900-1902). The following year he was promoted to Major General.

From 1906 to 1908, he was in command of U. S. forces in the Philippines.

Named Chief of Staff, U. S. Army in 1910.

* *

In the 1920 Republican Convention, he sought the Presidential nomination. And though he was the strongest contender in number of delegates, he was outflanked politically at the convention and lost the nomination.

* *

Was the Governor General of the Philippines from 1921-1927.

Awarded the Congressional Medal of Honor and the Distinguished Service Medal.

A fort in Missouri bears his name.

Can you name the doctor without turning to page 130?

Mediquiz

These questions are from a civil service examination recently given to candidates for physician appointments in municipal government.

Answers will be found on page 130.

1. Syncope following physical exertion suggests: (A) adrenal cortical adenoma; (B) pheochromocytoma; (C) islet cell adenoma of pancreas; (D) thyroid adenoma.

2. Crooke's hyalinization of cells is commonly associated with: (A) diabetes mellitus; (B) lupus erythematosus; (C) Cushing's syndrome; (D) acromegaly.

3. Acrocyanosis is a disturbance of the: (A) hemoglobin; (B) capillary bed; (C) platelets; (D) red cells.

4. The one of the following which is the best treatment for causalgia is: (A) rhizotomy; (B) chordotomy; (C) sympathectomy; (D) lobotomy.

5. To sympathectomize the lower extremities successfully, one must: (A) remove lumbar ganglions 1-2-3; (B) remove lumbar ganglions 3-4-5; (C) section sympathetic trunk between dorsal ganglions 8-9; (D) remove ganglion chain from D6 to L5.

6. A patient has a hard mass in the thyroid and osseous metastasis which show moderate uptake of radioactive iodine. The optimum treatment in this case is: (A) total thyroidectomy and systemic radioactive iodine therapy; (B) total thyroidectomy and irradiation of the metastasis; (C) irradiation of the gland and the metastasis; (D) systemic radioactive iodine therapy alone.

7. The one of the following with which Paget's disease of the bone (osteitis deformans) is most commonly associated is: (A) elevated serum calcium and diminished serum phosphorus; (B) elevated alkaline phosphatase; (C) elevated non-protein nitrogen; (D) reversal of the albuminglobulin ratio.

8. A bullet that may have grazed or perforated the ascending colon before lodging within the spinal canal has caused paraplegia. The one of the following which you would choose as the first measure in treatment is: (A) laminectomy for re-

moval of bullet; (B) observation for 24 hours; (C) exploratory laparatomy; (D) antibiotic therapy for 24 hours.

9. A small pupil, ptosis of the upper eyelid and enophthalmos (Horner's syndrome) indicate a spinal nerve root lesion at a vertebral level of: (A) cervical 1-2; (B) cervical 4-5; (C) cervical 7—thoracic 1; (D) thoracic 3-4.

10. The diagnosis of bladder neck obstruction due to benign or malignant enlargement of the prostate gland is best established by: (A) a cystogram; (B) urethrocystoscopy; (C) a rectal digital examination; (D) determination of amount of residual urine.

11. The anatomical structure usually involved in the production of a direct inguinal hernia is: (A) Poupart's ligament; (B) conjoint tendon; (C) external oblique fascia; (D) transversalis fascia.

12. The popliteal artery can be acutely occluded in the 6th decade and: (A) there is no danger of gangrene; (B) gangrene develops in 100 per cent of cases; (C) gangrene develops in two-thirds of cases; (D) gangrene develops in one third of cases.

13. Congenital arteriovenous fistulas of the forearm at times are accompanied by increased growth of the hand. This is most probably due to the fact that: (A) collateral arterial blood supply is stimulated by the fistulae and overnourishes the part; (B) increased venous pressure distal of the fistulae influences growth; (C) oxygen uptake by tissues distal to the fistulae is increased; (D) oxygenated blood is diverted into the venous system and nourishes the part by retrograded flow.

14. The age specific death rate for accidental death for males and females in the United States is highest in the age group: (A) 5 through 14 years; (B) 15 through 24 years; (C) 25 through 44 years; (D) 65 years and older.

15. Following a "head cold," a young man complains of slight dyspnea and a harassing cough productive of ½ 1 cup of non-foul, occasionally blood-streaked green mucopurulent sputum daily. Examination of the chest reveals scattered wheezes and rhonchi from apices to bases over both lung fields anteriorly, posteriorly and in the axillae. The chest X-ray is negative. The probable diagnosis of this illness is: (A) viral pneumonia; (B) acute tracheobronchitis; (C) bronchial asthma; (D) disseminated tuberculosis.

16. A young policeman complains of low grade fever, malaise, headache and increasing asthenia for one

week. Physical examination shows a temperature of 101°F. and hypertrophy of lymphoid tissue in posterior pharynx with generalized lymphadenopathy. The liver edge is palpable and tender and the edge of the spleen is palpable and tender. There is no icetrus. The diagnosis of this illness is most likely to be: (A) infectious mononucleosis; (B) Hodgkins disease; (C) acute leukemia; (D) infectious hepatitis.

17. Amebic hepatitis is best treated by: (A) needle aspiration of liver and injection of emetine hydrochloride; (B) open surgical drainage; (C) radiation X-ray therapy; (D) chloroquine therapy.

18. A 55-year-old man complains of easy fatigue, night sweats, weight loss of two weeks duration. Examination of blood reveals 8,000 white blood cells per cubic millimeter; 3,000,000 red blood cells per cubic millimeter; hemoglobin of 12.5 Gm./100 cc.; diminished number of platelets, occasional nucleated red cells and less than 1 per cent immature white cells. The one of the following diagnoses which is most unlikely is: (A) pernicious anemia in relapse; (B) aleukemic leukemia; (C) lupus erythematosus disseminatus; (D) multiple myeloma.

19. A 55-year-old male, who has worked in the quarries of Barre, Vermont, complains of dyspnea, marked peripheral edema and palpitations during the past three months. Examination reveals cyanosis, hepatomegaly, sinus tachycardia, fibrosis of the lungs and an elevated venous pressure. Treatment for this patient should include: (A) no oxygen; (B) quinidine to relieve the tachycardia; (C) digitalization; (D) a high carbohydrate diet.

20. The most useful of the following tests in the diagnosis of a suspected case of disseminated lupus erythematosus would be: (A) examination of the urine; (B) examination of the bone marrow; (C) examination of the blood for cold agglutinins; (D) erythrocyte sedimentation test.

21. The one of the following which does not occur in a patient receiving cortisone or corticotropin is: (A) peptic ulcer; (B) psychosis; (C) retention of potassium; (D) glycosuria.

22. Of the following, the one which is not a collagen disease is: (A) Hodgkin's disease; (B) lupus erythematosus disseminatus; (C) dermatomyositis; (D) scleroderma.

23. Recurrence of acute gout is best prevented by regular administration of small doses of (A) cinchophen; (B) colchicine; (C) salicylates; (D) benemid.

24. The one of the following drugs which is useful in the treatment of myasthenia gravis is: (A) curare;

(B) neostigmine; (C) cortisone; (D) quinidine.

25. The one of the following which is most helpful in establishing the diagnosis of polycystic renal disease is: (A) retrograde pyelogram; (B) asymptomatic uremia for a period of years; (C) family history of polycystic renal disease; (D) palpation of masses in both flanks.

26. The longest periods of survival with uremia are usually seen in patients with: (A) chronic glomerulonephritis; (B) polycystic renal disease; (C) intercapillary glomerulosclerosis; (D) unilateral atrophic pyelonephritis.

27. Systolic hypertension is commonly seen in association with: (A) coarctation of the aorta; (B) acute glomerulonephritis; (C) sclerosis of the aorta; (D) pheochromocytoma.

28. A "paradoxical pulse" is usually caused by: (A) cardiac tamponade; (B) myocardial infarction; (C) cardiac decompensation; (D) auricular fibrillation.

29. A "paradoxical pulse" is characterized by: (A) a faster rate during inspiration than during expiration; (B) a faster rate during expiration than during inspiration; (C) diminished force or absence during inspiration; (D) inequality of rates

at the cardiac apex and radial artery.

30. Of the following agents, the one which produces a persistent increase in plasma volume is: (A) dextran; (B) norepinephrine; (C) dextrose solution; (D) saline solution.

31. The child born of a mother who has had German measles during the last month of pregnancy is very apt to have: (A) congenital cardiac defects; (B) congenital cataract; (C) club foot; (D) none of the foregoing.

32. The one of the following which, in association with rheumatic heart disease, is most suggestive of subacute bacterial endocarditis is: (A) prolonged fever; (B) persistent microscopic hematuria; (C) a single blood culture positive for streptococcus viridans; (D) splenomegaly.

"My associates wish to check my diagnosis of acute common coryza."

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Patricia Edgerly

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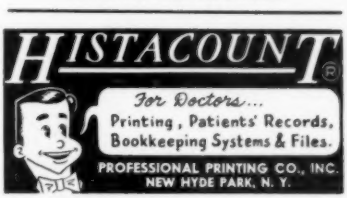

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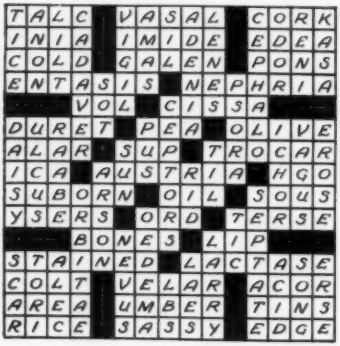
RESIDENT RELAXER

(puzzle on page 16)



WHAT'S THE DOCTOR'S NAME?

(from page 120)

Leonard Wood

VIEWBOX DIAGNOSIS

(from page 14)

SIMPLE ABSCESS

Note fluid level in left parahilar infiltration seen 10 days after tonsillectomy.

"MEDIQUIZ" ANSWERS

(from page 122)

1,C; 2,C; 3,B; 4,C; 5,A; 6,A; 7,B; 8,C; 9,C; 10,B; 11,D; 12,D; 13,A; 14,D; 15,B; 16,A; 17,D; 18,A; 19,C; 20,B; 21,C; 22,A; 23,B; 24,B; 25,A; 26,B; 27,C; 28,A; 29,C; 30,A; 31,D; 32,C.

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